CANCER REPORTING IN CALIFORNIA:

ABSTRACTING AND CODING PROCEDURES FOR HOSPITALS

CALIFORNIA CANCER REPORTING SYSTEM STANDARDS

VOLUME ONE

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

Collaborative Staging Task Force of the American Joint Committee on Cancer. ***Collaborative Staging Manual and Coding Instructions.*** *Version 1.0. Jointly published by American Joint Committee on Cancer (CHICAGO, IL) and U.S. Department of Health and Human Services (Bethesda, MD), 2004, NIH Publication Number 04-5496.*

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

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

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

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

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

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

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

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

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

Reporting Cancer Statistics

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

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

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

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

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

Book One-Objectives and Functions of a Tumor Registry. 2d ed, 1980. [New edition is in preparation.]

Book Two-Cancer Characteristics and Selection of Cases. 3d ed, 1992. NIH Pub. No. 92-993.

Book Three-Tumor Registrar Vocabulary: The Composition of Medical Terms. 2d ed, 1993. NIH Pub. No. 93-1078.

Book Four-Human Anatomy as Related to Tumor Formation. 2d ed, 1993. NIH Pub. No. 93-2161.

Book Five-Abstracting a Medical Record: Patient Identification, History, and Examinations. 2d ed, 1993. NIH Pub. No. 93-1263

Book Seven-Statistics and Epidemiology for Tumor Registrars. 1994.

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

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

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

It is sometimes difficult to identify a consultation-only case, especially at a large teaching hospital. As a guideline, the CCR recommends determination of who is ultimately responsible for treatment decisions and follow-up of the patient. If the reporting hospital is responsible, an abstract should be submitted. If the reporting hospital is confirming a diagnosis made elsewhere, rendering a second opinion, or recommending treatment to be delivered and managed elsewhere, an abstract is not required, although the regional registry should be notified of the case. When in doubt about whether or not to submit a report, either consult the regional registry or report the case.

II.1.8 NEWLY REPORTABLE HEMATOPOIETIC DISEASES (NRHD)

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

CHRONIC MYELOPROLIFERATIVE DISEASES	
Polycythemia vera	9950/3
Chronic myeloproliferative disease	9960/3
Myelosclerosis with myeloid metaplasia	9961/3
Essential thrombocythemia	9962/3
Chronic neutrophilic leukemia	9963/3
Hypereosinophilic syndrome	9964/3

MYELODYSPLASTIC SYNDROMES	
Refractory anemia	9980/3
Refractory anemia with sideroblasts	9982/3
Refractory anemia with excess blasts	9983/3
Refractory anemia with excess blasts in Transformation	9984/3
Refractory cytopenia with multilineage Dysplasia	9985/3
Myelodysplastic syndrome with 5q-syndrome	9986/3
Therapy related myelodysplastic syndrome	9987/3

OTHER NEW DIAGNOSES	
Langerhans cell histiocytosis, disseminated	9754/3
Acute biphenotypic leukemia	9805/3
Precursor lymphoblastic leukemia	983_/3
Aggressive NK cell leukemia	9948/3
Chronic neutrophilic leukemia	9963/3
Hypereosinophilic syndrome	9964/3

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

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

II.1.9 INTRACRANIAL/CNS TUMORS

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

II.1.9.1 Reportability. With the national implementation, any tumor diagnosed on January 1, 2004 or later with a behavior code of '0' or '1' will be collected for the following site codes based on ICD-O-3:

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

The histology codes (also based on ICD-O-3) have been expanded and are listed in Appendix V for ICD-O-3 Primary Brain and CNS Site/Histology Listing. Juvenile astrocytomas/pilocytic astrocytomas should continue to be reported as 9421/3.

Reportable Terminology. For non-malignant brain and CNS primaries, the terms "tumor" and "neoplasm" are diagnostic and reportable. The terms "mass" and "lesion" are not reportable for non-malignant brain and CNS primaries, but may be used for initial casefinding purposes. The terms "hypodense mass" or "cystic neoplasm" are not reportable even for CNS tumors. In order to be reportable, there must be a corresponding ICD-0-3 histology code for any CNS tumor related diagnosis.

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

Site(s)
Histologies
Timing
Laterality

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

Examples

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

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

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

Histologic groupings to determine same histology for non-malignant brain tumors

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

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

Example

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

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

Example

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

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

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

Example

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

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

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

Laterality. Beginning with malignant and benign/borderline CNS tumors diagnosed January 1, 2004 forward, the following sites require a laterality code of 1-4, or 9:

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

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

- If same site and same histology, and laterality is same side, one side unknown or not applicable, then single primary

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

Counting Non-Malignant Primaries

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

B = Benign/borderline tumor
M = Malignant tumor

Counting Malignant Primaries

Same Histology			*unless stated to be metastatic or recurrent					
Tumor		Timing (months)	Same Site			Different Site		
1st	2nd		Same side	Other side	Unkn side	Same side	Other side	Unkn side
M	M	< 2	1	1	1	2*	2*	2*
M	M	2 +	2*	2*	2*	2*	2*	2*
M	B	NA	2	2	2	2	2	2
Different Histology			**unless one histology is a specific subtype of the other					
Tumor		Timing (months)	Same Site			Different Site		
1st	2nd		Same side	Other side	Unkn side	Same side	Other side	Unkn side
M	M	<2	2**	2**	2**	2	2	2
M	M	2 +	2	2	2	2	2	2
M	B	NA	2	2	2	2	2	2

B = Benign/borderline tumor
M = Malignant tumor

II.1.9.3 Date of Diagnosis. *Since the CCR began reporting benign brain and CNS tumors prior to national reporting implementation, there are two sets of rules for establishing the Date of Diagnosis for benign and malignant brain tumors.*

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

Example

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

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

Example

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

II.1.9.4 Sequence Number. A primary non-malignant tumor of any of the sites specified on or after January 1, 2001 is reportable. The sequence number for the tumor is in the range 60-87. The sequencing of non-malignant tumors does not effect the sequencing of malignant tumors and vice versa. A malignancy (sequence 00) will remain 00 if followed by a non-malignant tumor (sequence 60-87).

Example

First tumor, benign meningioma, sequence 60
Second tumor, astrocytoma, sequence 00

II.1.9.5 Malignant Transformation. If a benign or borderline tumor transforms into a malignancy, abstract the malignancy as a new primary. If there is a change in WHO grade from a WHO I to a higher WHO grade, abstract as a new primary malignancy. If a malignant CNS tumor transforms into a higher grade tumor, do not change histology or grade and do not abstract as a new primary. This determination is made by the pathologist based on review of slides.

Example

Non-malignant WHO grade I to malignant WHO grade III. Complete two abstracts, one for the non-malignant tumor and one for the malignant tumor.

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

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

II.1.9.6 Tumor Grade. Always assign code 9 for non-malignant tumors. Do not code WHO grade in the 6th digit histology data field.

II.1.9.7 WHO Grade. Code the WHO grade classification as documented in the medical record in Collaborative Staging Site Specific Factor 1 for Brain and other Central Nervous System sites.

WHO grade I generally describes non-malignant or benign tumors; however, non-malignant tumors should not be coded as Grade I unless WHO grade is specifically stated in the source document.
WHO grade II generally describes a malignant tumor but it can describe a non-malignant tumor depending on histologic type.
WHO grade III and IV describe malignant tumors.
For certain types of CNS tumors, no WHO grade is assigned.

II.1.9.8. Staging.
For intracranial and CNS benign and borderline tumor cases diagnosed from January 1, 2001 to December 31, 2003, the CCR does not require that these cases be staged. The CCR recommends that these cases be coded as EOD 99 (Unknown). If your registry uses SEER Summary Stage, it is recommended that these cases be coded to 9. For intracranial and CNS benign and borderline tumor cases diagnosed January 1, 2004 forward, apply Collaborative Staging.

II.1.10 BORDERLINE OVARIAN TUMORS

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

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

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

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

STATE	For states in the U.S. and Canadian provinces, enter the standard two-letter Postal Service abbreviation. (California is CA. For other states, U.S. Territories and Canadian provinces, see Appendix B.) *For U.S. Territories with a postal abbreviation, such as Guam (GU), use the abbreviation or if no postal abbreviation enter "ZZ," not applicable. If the residence was in the U.S. or Canada, but the state or province is unknown, or the place of residence is unknown, enter "ZZ." For residents of countries other than the U.S. and Canada, and the country is known, enter "XX". For residents of countries other than the U.S. and Canada, and the country is unknown, enter "YY".*
ZIP	Enter the five-digit or nine-digit U.S. postal zip code or the proper postal code for any other country. When entering only five digits, leave the last spaces blank. If the patient resided outside the U.S. or Canada at time of diagnosis and the zip code is unknown, enter 8's in the entire field. To obtain an unknown zip code, consult the U.S. Postal Service National Zip Code and Post Office Directory, published by the U.S. Postal Service, or phone the local post office. If the code cannot be determined and it is a U.S. or Canadian resident, enter 9's in the entire field.
COUNTY	For California residents, enter the code for the county of residence at the time of diagnosis. (Appendix L contains a list of the codes used. CNExT automatically supplies the code if the county's name is entered.) Consult maps or reference works as needed to determine the correct county. Enter code 000 if the county of residence is not known or if it is a state and is other than California and its name is known. Enter code 220 for Canada, NOS, or the specific code for the known Canadian province (Canadian province codes are listed in Appendix C). If residence was in a foreign country, enter the country and CNExT will supply the code. (Country codes are listed in Appendix D.) If the state or country is not known, enter code 999. NOTE: To maintain consistency in the CCR database, codes must be entered as described above for state and county/country.

III.2.6 MARITAL STATUS

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

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

III.2.7 SEX

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

1 MALE
2 FEMALE
3 HERMAPHRODITE (persons with sex chromosome abnormalities)
4 TRANSSEXUAL (persons who have undergone sex-change surgery)
9 UNKNOWN

III.2.8 RELIGION

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

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

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

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

* Unless specified as Indian (code 03).
** Unless specified as Black (code 02).

III.2.9.2 Spanish/Hispanic* Origin. The Spanish/Hispanic Origin field is for identifying patients of Spanish or Hispanic origin or descent. The field corresponds to a question asked in the U.S. census of population. Included are people whose native tongue is Spanish, who are nationals of a Spanish-speaking Latin American country or Spain, and/or who identify with Spanish or Hispanic culture (such as Chicanos living in the American Southwest). Coding is independent of the Race field, since persons of Hispanic origin might be described as white, black, or some other race in the medical record. Spanish origin is not the same as birth in a Spanish-language country. Birthplace might provide guidance in determining the correct code, but do not rely on it exclusively. Information about birthplace is entered separately (see Section III.2.12). In the Spanish/Hispanic Origin field, enter one of the following codes:

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

The primary source for coding is an ethnic identifier stated in the medical record. If the record describes the patient as Mexican, Puerto Rican, or another specific ethnicity or origin included in codes 1 to 5, enter the appropriate code whether or not the patient's surname or maiden name is Spanish. If the patient has a Spanish surname, but the record contains information that he or she is not of Hispanic origin, use code 0, Non-Spanish. (American Indians and Filipinos frequently have Spanish surnames but are not considered to be of Spanish origin in the sense meant here.) Enter code 0 for Portuguese and Brazilians, because they are not Spanish. If the record does not state an origin that can be assigned to codes 1–5 and there is evidence other than surname that the person is Hispanic, use code 6, Spanish, NOS. If the record does not state an origin that can be assigned to codes 0-6, base the code on the patient's name, and use code 7, Spanish Surname Only. Use code 7, Spanish Surname Only, for a woman with a Spanish maiden name or a male patient with a Spanish Surname. If a woman's maiden name is not Spanish, use code 0, Non-Spanish, Non-Hispanic. But if her maiden name is not known or not applicable and she has a Spanish Surname, use code 7. If race is not known (Race code 99), use code 9, Unknown Whether Spanish or Not. Code 7, Spanish Surname Only (or code 6, Spanish, NOS, if diagnosed prior to January 1, 1994) may

IV.1.4 SCOPES

Note dates and positive and negative findings of laryngoscopies, sigmoidoscopies, mediastinoscopies, and other endoscopic procedures. Include mention of biopsies, washings, and other procedures performed during the examinations, but enter their results in the Pathology section. Record size of an observed lesion, if given. Enter "none" if no endoscopic examination was performed.

IV.1.5 LABORATORY TESTS

Enter dates, names, and results of laboratory tests or procedures used in establishing the diagnoses of neoplasms or metastases, such as serum protein electrophoresis for multiple myeloma or Waldenstrom's macroglobulinemia, serum alpha-fetoprotein (AFP) for liver cancer, and other tumor marker studies. Record T-and B-cell marker studies on leukemias and lymphomas, but enter hematology reports for leukemia and myeloma under Pathology. In leukemia cases where both bone marrow and chromosomes are analyzed, the bone-marrow results take precedence in coding histologic type (see Section IV.2), *unless more specific information is given in the cytogenetic report. Subcategories of acute myeloid leukemia are described according to cytogenetic abnormalities. If these abnormalities are included in a laboratory report, they take precedence in coding histologic type. The chromosome study or cytogenetic and molecular biological data* results can be recorded here. Enter "none" if no pertinent laboratory tests were performed.

IV.1.6 OPERATIVE FINDINGS

Record dates, names, and relevant findings of diagnostic surgical procedures, such as biopsies, dilation and curettage (D & C), and laparotomy. For definitive surgery entered under treatment (see Section VI.2.1-9), record pertinent findings. Note tumor size, if given, and any statements about observed nodes, even if they are not involved.

IV.1.7 PATHOLOGY

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

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

- Determine the method of diagnosis or confirmation.
- Identify all specimens examined microscopically.

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

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

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

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

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

Section IV.2
Diagnostic Confirmation

A gauge of the reliability of histologic and other data is the method of confirming that the patient has cancer. Coding for the confirmation field is in the order of the conclusiveness of the method, the lowest number taking precedence over other codes. The most conclusive method, microscopic analysis of tissue, is therefore coded as 1, while microscopic analysis of cells, the next most conclusive method, is coded as 2. Medical records should be studied to determine what methods were used to confirm the diagnosis of cancer, and the most conclusive method should be coded in the confirmation field. Since the confirmation field covers the patient's entire medical history in regard to the primary tumor, follow-up data (see Section VII.1) might change the coding. Although there is a priority order based on the most conclusive method of diagnosis, the clinical source utilized by the clinician to establish the cancer diagnosis should be used to select the best diagnostic confirmation code. The codes, in the order of their conclusiveness, are:

Microscopic Confirmation

1 POSITIVE HISTOLOGY
Use for microscopic confirmation based on biopsy, including punch biopsy, needle biopsy, bone-marrow aspiration, curettage, and conization. Code 1 also includes microscopic examination of frozen-section specimens and surgically removed tumor tissue, whether taken from the primary or a metastatic site. In addition, positive hematologic findings regarding leukemia *and NRHD* are coded 1. Cancers first diagnosed as a result of an autopsy or previously suspected and confirmed in an autopsy are coded 1 if microscopic examination is performed on the autopsy specimens.

2 POSITIVE CYTOLOGY, NO POSITIVE HISTOLOGY
Cytologic diagnoses based on microscopic examination of cells, rather than tissue. (Do not use code 2 if cancer is ruled out by a histologic examination.) Included are sputum, cervical, and vaginal smears; fine needle aspiration from breast or other organs; bronchial brushings and washings; tracheal washings; prostatic secretions; gastric, spinal, or peritoneal fluid; and urinary sediment. Also include diagnoses based on paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.

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

No Microscopic Confirmation

5 POSITIVE LABORATORY TEST OR MARKER STUDY
Clinical diagnosis of cancer based on certain laboratory tests or marker studies that are clinically diagnostic for cancer. Examples are the presence of alpha fetoprotein (AFP) for liver cancer and an abnormal electrophoretic spike for multiple myeloma or Waldenstrom's macroglobulinemia. Although an elevated PSA is nondiagnostic of cancer, if the physician uses the PSA as a basis for diagnosing prostate cancer with no other workup, record as code 5.

6 DIRECT VISUALIZATION WITHOUT MICROSCOPIC CONFIRMATION
Includes diagnoses by visualization and/or palpation during surgical or endoscopic exploration, or by gross autopsy. But do not use code 6 if visualization or palpation during surgery or endoscopy is confirmed by a positive histology or cytology report.

7 RADIOGRAPHY WITHOUT MICROSCOPIC CONFIRMATION
Includes all diagnostic radiology, scans, ultrasound, and other imaging technologies not confirmed by a positive histologic or cytologic report or by direct visualization.

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

9 UNKNOWN WHETHER OR NOT MICROSCOPICALLY CONFIRMED
(Death Certificate Only cases are included in code 9.)

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

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

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

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

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

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

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

V.3.5.4 In Situ. Medical reports ordinarily do not contain statements about differentiation of in situ lesions. But if a statement is made, enter the code indicated.

V.3.5.5 Brain Tumors. Magnetic Resonance Imaging (MRI) or Positron Emission Tomography (PET) can sometimes establish the grade of a brain tumor. If there is no tissue diagnosis, but grade or differentiation is stated in a MRI or PET report, base the grade code on the report. If there is a tissue diagnosis, however, do not base the grade code on any other source.

V.3.5.6 Gleason's Score. A special descriptive method, Gleason's Score, is used for prostate cancer. It is obtained by adding two separate numbers to produce a score in the range of 2 to 10. First, a number is assigned to the predominant (primary) pattern (i.e., the pattern that comprises more than half the tumor). Then a number is assigned to the lesser (secondary) pattern, and the two numbers are added to obtain Gleason's Score.

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

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

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

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

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

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

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

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

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

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

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

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

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

Section V.6
Tumor Markers

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

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

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

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

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

V.6.1 TUMOR MARKER 1

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

0 TEST NOT DONE (includes cases diagnosed at autopsy)

1 TEST DONE, RESULTS POSITIVE

2 TEST DONE, RESULTS NEGATIVE

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

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

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

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

8 TEST ORDERED, RESULTS NOT IN CHART

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

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

9 NOT APPLICABLE

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

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

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

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

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

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

V.6.2 TUMOR MARKER 2

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

0 TEST NOT DONE (includes cases diagnosed at autopsy)

1 TEST DONE, RESULTS POSITIVE

2 TEST DONE, RESULTS NEGATIVE

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

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

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

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

8 TEST ORDERED, RESULTS NOT IN CHART

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

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

9 NOT APPLICABLE

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

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

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

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

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

V.6.3 TUMOR MARKER 3

0 TEST NOT DONE (includes cases diagnosed at autopsy)

1 TEST DONE, RESULTS POSITIVE

2 TEST DONE, RESULTS NEGATIVE

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

4 RANGE 1: < 1.5 * N (S1)

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

6 RANGE 3: > 10 * N (S3)

8 TEST ORDERED, RESULTS NOT IN CHART

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

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

9 NOT APPLICABLE

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

0 NOT DONE (SX)

2 WITHIN NORMAL LIMITS (SO)

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

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

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

8 ORDERED, BUT RESULTS NOT IN CHART

9 UNKNOWN OR NO INFORMATION

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

V.6.4 TUMOR MARKER-CALIFORNIA-1

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

0 TEST NOT DONE (include cases diagnosed at autopsy)

1 TEST DONE, RESULTS POSITIVE

2 TEST DONE, RESULTS NEGATIVE

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

8 TESTS ORDERED, RESULTS NOT IN CHART

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

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

9 NOT APPLICABLE

Section V.7
AJCC Staging and Other ACoS Items

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

V.7.1 THE TNM SYSTEM

As the AJCC *Manual for Staging of Cancer* explains, the TNM system "is based on the premise that cancers of similar histology or site of origin share similar patterns of growth and extension. The size of the untreated cancer or tumor (T) increases progressively, and at some point in time regional lymph node involvement (N) and, finally, distant metastases (M) occur." Because classifications are different for each primary site, and coding for extension depends on precise anatomical identification, the AJCC manual must be referred to for data entry unless the coding is provided by physicians in the medical records. But fundamentally the system consists of assigning appropriate numbers or letters to the three fields: T (primary tumor), N (nodal involvement), and M (distant metastasis). For those sites not included in the AJCC Manual for Staging of Cancer, the Summary Staging Guide for Surveillance Epidemiology and End Results Group (SEER) is to be used. For a list of these sites, please refer to the *AJCC Manual for Staging of Cancer, 6th Edition.*

V.7.2 DATA ENTRY

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

V.7.3 TNM STAGE BASIS

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

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

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

T CODES:

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

N CODES:

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

M CODES:

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

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

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

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

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

V.7.5 AJCC STAGE GROUP (CLINICAL AND PATHOLOGICAL)

The AJCC manual contains instructions for coding summaries of TNM staging. When entering a stage–summary code, be sure to include any letter used for the tumor–for example, 3A, 2C. If there is no letter, leave the second digit in the field blank. The codes are:

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

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

Record who was responsible for performing the TNM staging on the case. The TNM Coder (Clinical) and TNM Coder (Pathological) are to be used in conjunction with clinical and pathological TNM staging. These fields will be transmitted to the regional and state registries. CNExT will have the TNM Coder (Other) field available for hospitals, but it will not be transmitted. The codes are as follows:

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

V.7.7 TNM EDITION

Record which edition of TNM staging was used to stage a case. The codes are as follows:

00 NOT STAGED
01 FIRST EDITION
02 SECOND EDITION
03 THIRD EDITION
04 FOURTH EDITION
05 FIFTH EDITION
06 SIXTH EDITION
88 NOT APPLICABLE (cases that do not have an AJCC staging scheme and staging was not done)
99 UNKNOWN

May be left blank

V.7.8 PEDIATRIC STAGE

This scheme is to be used for the purpose of entering the stage for pediatric patients only. This includes patients who are younger than twenty (20) years of age and diagnosed January 1, 1996 or later. For patients twenty years of age and older, this field would be coded 88 - not applicable. Use code 99 for pediatric leukemia cases. For cases diagnosed prior to 1996, both pediatric and non-pediatric, this field may be left blank. Record the stage assigned by the Managing Physician. The codes are as follows:

7 SENTINEL NODE BIOPSY AND CODE 3,4, OR 5 AT DIFFERENT TIMES
Code 2 was followed in a subsequent surgical event by procedures coded as 3, 4, or 5

9 UNKNOWN OR NOT APPLICABLE
It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; primaries of the brain and central nervous system; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

Cases diagnosed prior to January 1, 2003 are to be coded in a new field, Scope of Regional LN 98-02. Refer to Appendix Q-1 for these codes.

Each site contains a list of nodes which are regional. Any nodes not contained on these lists are distant and should be coded in Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

In Appendix Q-1 for head and neck primaries diagnosed prior to January 1, 2003, these fields are to be used for neck dissections. Codes 2-5 indicate only that a neck dissection procedure was done, they do not imply that nodes were found during the pathologic examination of the surgical specimen. Code the neck dissection even if no nodes were found in the specimen.

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

VI.2.3 NUMBER OF REGIONAL LYMPH NODES EXAMINED

Record the number of lymph nodes identified in the pathology report during each surgical procedure of the regional lymph nodes. The codes are the same for all sites. Please refer to Appendix Q-1 for these codes. These are to be entered in chronological order. If no regional lymph nodes were identified in the pathology report, leave the field blank even if the surgical procedure includes a lymph node dissection (i.e., modified radical mastectomy) or if the operative report documents removal of the nodes. CNEXT will fill the fields with 00. The Summary field will be computed automatically by CNEXT. It will contain the number of nodes associated with the highest coded regional lymph node surgery. If no nodes were identified in the specimen from this procedure, then the Summary field will contain 00. NOTE: This field is not cumulative. It does not replace or duplicate the "Regional Lymph Nodes Examined" field used in Extent of Disease coding.

Effective with cases diagnosed on or after January 1, 2003, the fields for Rx Summ-Reg LN Examined and Rx Hosp-Reg LN Examined are no longer required by the CCR and the CoC. Information regarding the number of lymph nodes has been incorporated into the scope fields. However, the summary field for cases diagnosed prior to January 1, 2003 must continue to be coded.

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

VI.2.4 SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S), OR DISTANT LYMPH NODES

There are three one-character fields to be used to record removal of tissue other than the primary tumor or organ of origin. This would not be an en bloc resection. See example #1. Code the removal of non-primary site tissue which the surgeon may have suspected to be involved with malignancy even if the pathology was negative. Do not code the incidental removal of tissue for reasons other than malignancy. See example #2. These procedures are to be entered in chronological order. If no surgery was performed of other regional or distant sites or distant lymph nodes, leave the fields blank. They will be filled with 0 by CNExT. The Summary field will be computed automatically by CNExT.

Starting with cases diagnosed January 1, 2003 forward, RX Summ - Surg Oth Reg/Dis and its corresponding procedure fields will not be coded according to site. It will be coded using a single scheme for all sites. The new codes are as follows:

0 NONE
No surgical procedure of nonprimary site

1 NONPRIMARY SURGICAL PROCEDURE PERFORMED
Nonprimary surgical resection to other site(s), unknown if whether the site(s) is regional or distant.

2 NONPRIMARY SURGICAL PROCEDURE TO OTHER REGIONAL SITES
Resection of regional site.

3 NONPRIMARY SURGICAL PROCEDURE TO DISTANT LYMPH NODE(S)
Resection of distant lymph node(s).

4 NONPRIMARY SURGICAL PROCEDURE TO DISTANT SITE
Resection of distant site.

5 COMBINATION OF CODES
Any combination of surgical procedures 2, 3, or 4.

9 UNKNOWN
It is unknown whether any surgical procedure of a nonprimary site was performed. Death certificate only.

NOTE: Use code 1 if any surgery is performed to treat tumors of Unknown or Ill-defined Primary sites (C76.0-76.8, C80.9) or for Hematopoietic/Reticuloendothelial/Immunoproliferative disease (C42.0, C42.1, C42.3, C42.4, or 9750, 9760-9764, 9800-9820, 9826, 9831-9964, 9980-9989).

0 NONE
1 BEAM RADIATION
2 RADIOACTIVE IMPLANTS
3 RADIOISOTOPES
4 COMBINATION OF 1 WITH 2 OR 3
5 RADIATION, NOS (method or source not specified)
9 UNKNOWN IF RADIATION THERAPY RECOMMENDED OR GIVEN

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

Beginning with cases diagnosed January 1, 1998, radiation to the brain and central nervous system for lung cancers and leukemias only is to be recorded in the Radiation Summary and Radiation At This Hospital fields. Include prophylactic treatment and treatment of known spread to the CNS.

Beginning with cases diagnosed on or after January 1, 2003 or cases entered after the software conversion, radiation to the brain and CNS for lung and leukemia cases are to be coded in the Radiation – Regional RX Modality and Radiation – Boost RX Modality fields. As stated previously, software conversion of these two fields will generate the Radiation Therapy Summary field.

VI.3.3 RADIATION - REGIONAL RX MODALITY

Record the dominant modality of radiation therapy used to deliver the most clinically significant regional dose to the primary volume of interest during the first course of treatment. The CCR requires the collection of this field. As noted above, this data item and Radiation - Boost RX Modality will be converted to generate the RX Summ - Radiation.

There is no corresponding "At this Hospital" field. The codes for Radiation - Regional RX Modality are as follows:

00 NO RADIATION TREATMENT; *DIAGNOSED AT AUTOPSY*
20 EXTERNAL BEAM, NOS
21 ORTHOVOLTAGE
22 COBALT-60, CESIUM-137
23 PHOTONS (2-5 MV)
24 PHOTONS (6-10 MV)
25 PHOTONS (11-19 MV)
26 PHOTONS (>19 MV)
27 PHOTONS (MIXED ENERGIES)
28 ELECTRONS
29 PHOTONS AND ELECTRONS MIXED
30 NEUTRONS, WITH OR WITHOUT PHOTONS/ELECTRONS
31 IMRT
32 CONFORMAL OR 3-D THERAPY
40 PROTONS
41 STEREOTACTIC RADIOSURGERY, NOS
42 LINAC RADIOSURGERY, NOS
43 GAMMA KNIFE
50 BRACHYTHERAPY, NOS

51 BRACHYTHERAPY, INTRACAVITARY, LDR
52 BRACHYTHERAPY, INTRACAVITARY, HDR
53 BRACHYTHERAPY, INTERSTITIAL, LDR
54 BRACHYTHERAPY, INTERSTITIAL, HDR
55 RADIUM
60 RADIOISOTOPES, NOS
61 STRONTIUM-89
62 STRONTIUM-90
80* COMBINATION MODALITY, SPECIFIED*
85* COMBINATION MODALITY, NOS*
98 OTHER, NOS
99 *UNKNOWN; DEATH CERTIFICATE ONLY*

Clarification: Intracavitary use of Cobalt-60 or Cesium-137 should be coded as 50 or 51. (See FORDS Manual for code definitions).

There is no hierarchy for this data item. If multiple radiation therapy modalities are used to treat the patient, code the dominant modality. In the rare occasion where 2 modalities are combined in a single volume (IMRT photons with an electron "patch" for example), code the appropriate radiation modality item to the highest level of complexity, i.e. the IMRT.

*NOTE: For cases diagnosed prior to January 1, 2003, the codes reported in this data item describe any radiation administered to the patient as part or all of the first course of therapy. Codes 80 and 85 describe specific converted descriptions of radiation therapy coded according to *Vol. II, ROADS,* and *DAM* rules and **should not** be used to record regional radiation for cases diagnosed on or later than January 1, 2003.

VI.3.4 RADIATION – BOOST RX MODALITY

Record the dominant modality of radiation therapy used to deliver the most clinically significant boost dose to the primary volume of interest during the first course of treatment. This is accomplished with external beam fields of reduced size (relative to the regional treatment fields), implants, stereotactic radiosurgery, conformal therapy, or IMRT. External beam boosts may consist of two or more successive phases with progressively smaller fields generally coded as a single entity.

The CCR requires the collection of this field. As noted above, this data item and Radiation - Regional RX Modality will be converted to generate the RX Summ - Radiation. There is no corresponding "At this Hospital" field. The codes are as follows:

00 NO BOOST TREATMENT*; DIAGNOSED AT AUTOPSY*
20 EXTERNAL BEAM, NOS
21 ORTHOVOLTAGE
22 COBALT-60, CESIUM-137
23 PHOTONS (2-5 MV)
24 PHOTONS (6-10 MV)
25 PHOTONS (11-19 MV)
26 PHOTONS (>19 MV)
27 PHOTONS (MIXED ENERGIES)
28 ELECTRONS
29 PHOTONS AND ELECTRONS MIXED

30 NEUTRONS, WITH OR WITHOUT PHOTONS/ELECTRON
31 IMRT
32 CONFORMAL OR 3-D THERAPY
40 PROTONS
41 STEREOTACTIC RADIOSURGERY, NOS
42 LINAC RADIOSURGERY, NOS
43 GAMMA KNIFE
50 BRACHYTHERAPY, NOS
51 BRACHYTHERAPY, INTRACAVITARY, LDR
52 BRACHYTHERAPY, INTRACAVITARY, HDR
53 BRACHYTHERAPY, INTERSTITIAL, LDR
54 BRACHYTHERAPY, INTERSTITIAL, HDR
55 RADIUM
60 RADIOISOTOPES, NOS
61 STRONTIUM-89
62 STRONTIUM-90
98 OTHER, NOS
99 UNKNOWN*; DEATH CERTIFICATE ONLY*

Clarification: Intracavitary use of Cobalt-60 or Cesium-137 should be coded as 50 or 51. (See the FORDS Manual for code definitions).

There is no hierarchy for this data item. If multiple radiation therapy boost modalities are used to treat the patient, code the dominant modality.

VI.3.5 DATE OF RADIATION THERAPY

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

00000000 NO RADIATION THERAPY ADMINISTERED; AUTOPSY ONLY CASE.

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

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

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

VI.3.6 REASON FOR NO RADIATION

The following codes are to be used to record the reason the patient did not undergo radiation treatment:

0 RADIATION TREATMENT PERFORMED

1 RADIATION TREATMENT NOT PERFORMED BECAUSE IT WAS NOT A PART OF THE PLANNED FIRST COURSE TREATMENT

2 RADIATION CONTRAINDICATED BECAUSE OF OTHER CONDITIONS OR OTHER PATIENT RISK FACTORS (CO-MORBID CONDITIONS, ADVANCED AGE, ETC)

5 RADIATION TREATMENT NOT PERFORMED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED TREATMENT

6 RADIATION TREATMENT WAS RECOMMENDED BUT NOT PERFORMED. NO REASON WAS NOTED IN THE PATIENT'S RECORD.

7 RADIATION TREATMENT WAS RECOMMENDED BUT REFUSED BY THE PATIENT, FAMILY MEMBER OR GUARDIAN. THE REFUSAL IS NOTED IN THE PATIENT'S RECORD.

8 RADIATION RECOMMENDED, UNKNOWN IF DONE

9 UNKNOWN IF RADIATION RECOMMENDED OR PERFORMED; DEATH CERTIFICATE AND AUTOPSY ONLY CASES

NOTE: Include radiation to the brain and central nervous system when coding this field.

NOTE: Beginning with cases diagnosed 1/1/2003, a new code - Code 5 - radiation not performed because patient died was added. Definitions for codes 1, 2, and 6 were also modified.

VI.3.7 RADIATION SEQUENCE WITH SURGERY

Code the sequence in which radiation and surgical procedures were performed as part of the first course of treatment. Use the following codes:

0 NOT APPLICABLE treatment did not include both surgery and radiation, or unknown whether both were administered; *diagnosed at autopsy*
2 RADIATION BEFORE SURGERY
3 RADIATION AFTER SURGERY
4 RADIATION BOTH BEFORE AND AFTER SURGERY
5 INTRAOPERATIVE RADIATION
6 INTRAOPERATIVE RADIATION WITH OTHER RADIATION GIVEN BEFORE OR AFTER SURGERY
9 SEQUENCE UNKNOWN, BUT BOTH SURGERY AND RADIATION WERE GIVEN

If first course of treatment includes (codes 10–90 in Surgery of the Primary Site fields, codes 1-7 in the Scope of Regional Lymph Node Surgery fields, and codes 1-8 in the Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) fields) and radiation, use codes 2–9. For all other cases, use code 0.

Section VI.4
First Course of Treatment: Chemotherapy

Chemotherapy includes the use of any chemical to attack or treat cancer tissue, unless the chemical achieves its effect through change of the hormone balance or by affecting the patient's immune system. In coding consider only the agent, not the method of administering it, although the method of administration may be recorded. Chemotherapy typically is administered orally, intravenously, or intracavitarily, and sometimes topically or by isolated limb perfusion. The drugs are frequently given in combinations that are referred to by acronyms or protocols. Do not record the protocol numbers alone. Two or more single agents given at separate times during the first course of cancer directed therapy are considered to be a combination regimen.

VI.4.1 NAMES OF CHEMOTHERAPEUTIC AGENTS

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

VI.4.2 CHEMOTHERAPY CODES

Use the following codes for recording chemotherapy in the Summary field. Use codes 00-87 for recording chemotherapy in the At This Hospital field.

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

01 CHEMOTHERAPY, NOS.

02 SINGLE AGENT CHEMOTHERAPY

03 MULTIAGENT CHEMOTHERAPY ADMINISTERED AS FIRST COURSE THERAPY

82 CHEMOTHERAPY WAS NOT RECOMMENDED/ADMINISTERED DUE TO CONTRAINDICATIONS.

85 CHEMOTHERAPY NOT ADMINISTERED BECAUSE THE PATIENT DIED.

86 CHEMOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT WAS NOT ADMINISTERED AS PART OF THE FIRST COURSE OF THERAPY. NO REASON WAS STATED IN PATIENT RECORD.

87 CHEMOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT THIS TREATMENT WAS REFUSED BY THE PATIENT, A PATIENT'S FAMILY MEMBER, OR THE PATIENT'S GUARDIAN. THE REFUSAL WAS NOTED IN PATIENT RECORD.

88 CHEMOTHERAPY WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.

99 IT IS UNKNOWN WHETHER A CHEMOTHERAPEUTIC AGENT(S) WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

VI.4.3 DATE OF CHEMOTHERAPY

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

00000000 NO CHEMOTHERAPY ADMINISTERED; AUTOPSY ONLY CASE.

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

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

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

VI.5.3 HORMONE (ENDOCRINE) RADIATION

This data item is coded in the "Transplant/Endocrine Procedure" field (Section VI.7). Report any type of radiation directed toward an endocrine gland to affect hormonal balance if:

- The treatment is for cancers of the breast and prostate.
- Both paired glands (ovaries, testes, adrenals) or all of a remaining gland have been irradiated.

VI.5.4 HORMONE THERAPY CODES

Use the following codes for recording hormone therapy in the Summary field. Use codes 00-87 for recording hormone therapy at this hospital. The codes for Reason No Hormone have been incorporated into this field.

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

01 HORMONE THERAPY ADMINISTERED AS FIRST COURSE THERAPY.

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

85 HORMONE THERAPY WAS NOT ADMINISTERED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED THERAPY.

86 HORMONE THERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT WAS NOT ADMINISTERED AS PART OF THE FIRST COURSE THERAPY. NO REASON WAS STATED IN PATIENT RECORD.

87 HORMONE THERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT THIS TREATMENT WAS REFUSED BY THE PATIENT, A PATIENT'S FAMILY MEMBER, OR THE PATIENT'S GUARDIAN. THE REFUSAL WAS NOTED IN THE PATIENT RECORD.

88 HORMONE THERAPY WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.

99 IT IS UNKNOWN WHETHER A HORMONAL AGENT(S) WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

VI.5.5 DATE OF HORMONE THERAPY

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

00000000 NO HORMONE THERAPY ADMINISTERED; AUTOPSY ONLY CASE

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

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

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

Section VI.6
First Course of Treatment:
Immunotherapy
(Biological Response Modifier Therapy)

Immunotherapy/Biological response modifier therapy (BRM) is a generic term covering everything done to the immune system to alter it or change the host response to a cancer (defense mechanism).

VI.6.1 IMMUNOTHERAPY AGENTS

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

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

VI.6.2 IMMUNOTHERAPY CODES

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

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

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

01 IMMUNOTHERAPY ADMINISTERED AS FIRST COURSE THERAPY

82 IMMUNOTHERAPY WAS NOT RECOMMENDED/ADMINISTERED BECAUSE IT WAS CONTRAINDICATED DUE TO PATIENT RISK FACTORS (i.e. COMORBID CONDITIONS, ADVANCED AGE).

85 IMMUNOTHERAPY WAS NOT ADMINISTERED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED THERAPY.

86 IMMUNOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT WAS NOT ADMINISTERED AS PART OF THE FIRST COURSE OF THERAPY. NO REASON WAS STATED IN PATIENT RECORD.

87 IMMUNOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT THIS TREATMENT WAS REFUSED BY THE PATIENT, A PATIENT'S FAMILY MEMBER, OR THE PATIENT'S GUARDIAN. THE REFUSAL WAS NOTED IN THE PATIENT RECORD.

88 IMMUNOTHERAPY WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.

99 IT IS UNKNOWN WHETHER AN IMMUNOTHERAPEUTIC AGENT(S) WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

VI.6.3 DATE OF IMMUNOTHERAPY

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

00000000 NO IMMUNOTHERAPY ADMINISTERED; AUTOPSY ONLY CASE.

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

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

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

Section VI.7
First Course of Treatment:
Transplant/Endocrine Procedures

Record systemic therapeutic procedures administered as part of first course of treatment. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy. Information on transplants and endocrine procedures was removed from the Rx Summ - BRM (Immunotherapy) field and moved to this field. Bone marrow and stem cell procedures are now coded in this field along with endocrine surgery or radiation. A conversion will be required for cases diagnosed prior to January 1, 2003 using both the Rx Summ - BRM (Immunotherapy) and Rx Summ - Hormone fields. Although the CoC did not add a corresponding "At this Hospital" field, the CCR will be requiring this field in order to provide consistency, i.e.; all of the other treatment fields except radiation have a hospital-level field.

There is no text field for bone marrow transplant and endocrine procedures. Record text information regarding bone marrow transplants and endocrine procedures in the immunotherapy text field.

VI.7.1 TRANSPLANT/ENDOCRINE CODES

Use the following codes for recording transplant/endocrine procedures in the Summary field.
Use codes 00-87 for recording transplant/endocrine procedures in the At This Hospital Field

00 NO TRANSPLANT PROCEDURE OR ENDOCRINE THERAPY WAS ADMINISTERED AS PART OF THE FIRST COURSE THERAPY. *DIAGNOSED AT AUTOPSY.*

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

11 BONE MARROW TRANSPLANT-AUTOLOGOUS

12 BONE MARROW TRANSPLANT-ALLOGENEIC

20 STEM CELL HARVEST *AND INFUSION*

30 ENDOCRINE SURGERY AND/OR ENDOCRINE RADIATION THERAPY

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

82 HEMATOLOGIC TRANSPLANT AND/OR ENDOCRINE SURGERY/RADIATION WERE NOT RECOMMENDED/ADMINISTERED BECAUSE IT WAS CONTRAINDICATED DUE TO PATIENT RISK FACTORS (i.e., COMORBID CONDITIONS, ADVANCED AGE).

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

86 HEMATOLOGIC TRANSPLANT AND/OR ENDORCRINE SURGERY/RADIATION WERE NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT WAS NOT ADMINISTERED AS PART OF THE FIRST COURSE THERAPY. NO REASON WAS STATED IN PATIENT RECORD.

87 HEMATOLOGIC TRANSPLANT AND/OR ENDORCRINE SURGERY/RADIATION WERE NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT THIS TREATMENT WAS REFUSED BY THE PATIENT, A PATIENT'S FAMILY MEMBER, OR THE PATIENT'S GUARDIAN. THE REFUSAL WAS NOTED IN PATIENT RECORD.

88 HEMATOLOGIC TRANSPLANT AND/OR ENDOCRINE SURGERY/RADIATION WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.

99 IT IS UNKNOWN WHETHER HEMATOLOGIC TRANSPLANT AND/OR ENDOCRINE SURGERY/RADIATION WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

V1.7.2 DATE OF TRANSPLANT/ENDOCRINE PROCEDURE

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

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

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

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

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

Section VI.8
First Course Treatment: Other Therapy

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

- Tumor embolization (arterial block), if the surgeon's intent is to kill tumor cells.
- Hyperbaric oxygen (as adjunct to definitive treatment).
- Hyperthermia (given alone or in combination with chemotherapy, as in isolated heated limb perfusion for melanoma).
- Any experimental drug that cannot be classified elsewhere.
- Double blind clinical trial information where the type of agent administered is unknown and/or there is any use of a placebo. However, after the code is broken, report the treatment under the appropriate category (a correction record should be submitted when the data are available).
- Unorthodox and unproven treatment, such as laetrile or krebiozen.
- For Newly Reportable Hematopoietic Diseases (NRHD) only, specify in the Remarks field and use code 1 "Other Therapy" for the following:

    - Transfusions/Plasmapheresis
    - Phlebotomy/Blood Removal
    - Supportive Care
    - Aspirin
    - Observation

VI.8.1 OTHER THERAPY CODES

Use the following codes for recording other therapy in the Summary field. Use codes 0-7 for recording other therapy in the At This Hospital Field.

0 NO OTHER CANCER DIRECTED THERAPY EXCEPT AS CODED ELSEWHERE. *DIAGNOSED AT AUTOPSY.*
1 OTHER CANCER DIRECTED THERAPY
2 OTHER EXPERIMENTAL CANCER DIRECTED THERAPY (not included elsewhere)
3 DOUBLE BLIND CLINICAL TRIAL, CODE NOT YET BROKEN
6 UNPROVEN THERAPY
7 PATIENT OR PATIENTS GUARDIAN REFUSED THERAPY WHICH WOULD HAVE BEEN CODED 1-3 ABOVE
8 OTHER CANCER DIRECTED THERAPY RECOMMENDED, UNKNOWN IF ADMINISTERED
9 UNKNOWN IF OTHER THERAPY RECOMMENDED OR ADMINISTERED. *DEATH CERTIFICATE ONLY.*

VI.8.2 DATE OF OTHER THERAPY

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

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

Section IX.2
Quality Control

The CCR and regional registries have procedures for assuring the quality of the data produced by the reporting system. Staff from both the regional registry and the CCR visit cancer-reporting facilities to perform quality control audits. The CCR has established uniform standards of quality for hospital data in three areas: completeness, accuracy, and timeliness.

IX.2.1 COMPLETENESS

Completeness, the extent to which all required cases have been reported, is assessed by a casefinding audit performed at the reporting facility and by monitoring of death certificates. The minimum acceptable level of completeness for a reporting facility is 97 percent. (See Section II, Reportable Neoplasms, for a discussion of which cases must be abstracted. Descriptions of the protocols and procedures for evaluating completeness are available from the CCR.)

IX.2.2 ACCURACY

Accuracy is the extent to which the data submitted match the information in the medical record and have been correctly coded. It encompasses accurate abstracting, correct application of coding rules, and correct entry into and retrieval from the computer.

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

The CCR's software contains a number of edits that require review. After review and confirmation that the abstracted information is correct, a flag must be set so that repeated review is not necessary and a case can be set to complete. Many hospital registry software programs also contain these over-ride flags. See Appendix T for a list of these over-rides. Please follow the instructions provided by your hospital software vendor for using these flags.

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

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

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

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

*Counted as one discrepancy

The visual editing accuracy rate for the thirteen data items was established at 97%. These data items were selected because they affect the overall quality for data usage. This rate applies to cancer reporting facilities and not to individual cancer registry abstractors. The reporting facility is responsible for cancer reporting requirements, not specific individuals; therefore, an accuracy rate reflects the facility's compliance with regulations.

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

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

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

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

Another method of assessing accuracy is to reabstract cases in the hospitals. A sample of cases from each facility is reabstracted by specially trained personnel. The measure used is the number of discrepancies found in related categories of items.

IX.2.3 TIMELINESS

Timeliness involves how quickly the reporting hospital submits a case to a regional registry after admission of the patient. Regional registries monitor the timeliness of data submitted by hospitals. The standard set by CCR is that 97 percent of cases must be received by the regional registry within six months of admission and 100 percent must be received within 12 months of admission.

Although every effort should be made to complete cases before they are transmitted to the regional registry, it is recognized that some cancer cases undergo treatment later than six-months from the date of admission. If these or other cases are going to exceed the six-month due date, they must be transmitted without treatment data and this must be documented on the abstract. This treatment information must be submitted later in a correction record. These correction records should not be sent in any later than two months after the six-month deadline, or eight months after the date of admission. If these corrections will be sent in later than eight months because treatment has not been completed, the region must be notified.

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

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

CANADIAN PROVINCE/ TERRITORY

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

APPENDIX H
SUMMARY OF CODES

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

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

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

III.2.4 & VII.3.2	Phone	Ten-digit telephone number, including area code; no hyphens; may be blank; enter 0's for no phone
III.2.6	Marital Status	1 SINGLE 2 MARRIED 3 SEPARATED 4 DIVORCED 5 WIDOWED 9 UNKNOWN
III.2.7	Sex	1 MALE 2 FEMALE 3 HERMAPHRODITE 4 TRANSSEXUAL 9 UNKNOWN
III.2.8	Religion	Two-digit code (see Appendix G)
III.2.9.1	Race 1	01 WHITE 02 BLACK 03 AMERICAN INDIAN, ALEUTIAN, OR ESKIMO 04 CHINESE 05 JAPANESE 06 FILIPINO 07 HAWAIIAN 08 KOREAN 09 ASIAN INDIAN, PAKISTANI 10 VIETNAMESE 11 LAOTIAN 12 HMONG 13 KAMPUCHEAN (CAMBODIAN) 14 THAI 20 MICRONESIAN, NOS 21 CHAMORRO 22 GUAMANIAN, NOS 25 POLYNESIAN, NOS 26 TAHITIAN 27 SAMOAN 28 TONGAN 30 MELANESIAN, NOS 31 FIJI ISLANDER 32 NEW GUINEAN 90 OTHER SOUTH ASIAN*, INCLUDING BANGLADESHI, BHUTANESE, NEPALESE, SIKKIMESE, SRI LANKAN (CEYLONESE) 96 OTHER ASIAN, INCLUDING BURMESE, INDONESIAN, ASIAN, NOS AND ORIENTAL, NOS 97 PACIFIC ISLANDER, NOS 98 OTHER 99 UNKNOWN

III.2.9.1 Race 2-5

01	WHITE
02	BLACK
03	AMERICAN INDIAN, ALEUTIAN, OR ESKIMO
04	CHINESE
05	JAPANESE
06	FILIPINO
07	HAWAIIAN
08	KOREAN
09	ASIAN INDIAN, PAKISTANI
10	VIETNAMESE
11	LAOTIAN
12	HMONG
13	KAMPUCHEAN (CAMBODIAN)
14	THAI
20	MICRONESIAN, NOS
21	CHAMORRO
22	GUAMANIAN, NOS
25	POLYNESIAN, NOS
26	TAHITIAN
27	SAMOAN
28	TONGAN
30	MELANESIAN, NOS
31	FIJI ISLANDER
32	NEW GUINEAN
88	NO FURTHER RACE DOCUMENTED
90	OTHER SOUTH ASIAN*, INCLUDING BANGLADESHI, BHUTANESE, NEPALESE, SIKKIMESE, SRI LANKAN (CEYLONESE)
96	OTHER ASIAN, INCLUDING BURMESE, INDONESIAN, ASIAN, NOS AND ORIENTAL, NOS
97	PACIFIC ISLANDER, NOS
98	OTHER
99	UNKNOWN

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

III.2.9.2 Spanish Hispanic/Origin

0	NON-SPANISH, NON-HISPANIC
1	MEXICAN (including CHICANO, NOS)
2	PUERTO RICAN
3	CUBAN
4	SOUTH OR CENTRAL AMERICAN (except BRAZILIAN)
5	*OTHER SPECIFIED SPANISH ORIGIN (includes EUROPEAN; excludes DOMINICAN REPUBLIC (for cases diagnosed on or after January 1, 2005 forward)*
6	SPANISH, NOS; HISPANIC, NOS, LATINO, NOS (evidence that Hispanic cannot be assigned to codes 1-5)
7	SPANISH SURNAME ONLY (only evidence is surname or maiden name)*
8	*DOMINICAN REPUBLIC (for cases diagnosed on or after January 1, 2005)*
9	UNKNOWN WHETHER SPANISH OR NOT

*Use Appendix O to code this field.

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

V.7.4	TNM-N Code Pathological	Site-specific code, one, two, or three characters (ACoS), flush left
V.7.4	TNM-M Code Pathological	Site-specific code, two characters (ACoS)
V.7.5	TNM Stage-(Clinical & Pathological)	Site-specific code, one or two characters (ACoS), entered as Arabic (not Roman) numerals; flush left
V.7.6	TNM Coder (Clinical) (Pathological), and (Other) (ACoS)	0 NOT STAGED 1 MANAGING PHYSICIAN 2 PATHOLOGIST 3 OTHER PHYSICIAN 4 ANY COMBINATION OF 1, 2 OR 3 5 REGISTRAR 6 ANY COMBINATION OF 5 WITH 1, 2 OR 3 7 OTHER 8 STAGED, INDIVIDUAL NOT SPECIFIED 9 UNKNOWN IF STAGED
V.7.7	TNM Edition (ACoS)	00 NOT STAGED 01 FIRST EDITION 02 SECOND EDITION 03 THIRD EDITION 04 FOURTH EDITION 05 FIFTH EDITION 06 SIXTH EDITION 88 NOT APPLICABLE (cases that do not have an AJCC staging scheme and staging was not done) 99 UNKNOWN May be left blank

VI.3.2	Radiation (Generated field for cases diagnosed on or after January 1, 2003)	0 NONE 1 BEAM RADIATION 2 RADIOACTIVE IMPLANTS 3 RADIOISOTOPES 4 COMBINATION OF 1 WITH 2 OR 3 5 RADIATION, NOS-METHOD OR SOURCE NOT SPECIFIED 9 UNKNOWN IF RADIATION THERAPY RECOMMENDED OR GIVEN NOTE: Code 6 may appear in converted cases.
VI.3.3	Radiation- Regional RX Modality	00 NO RADIATION TREATMENT; *DIAGNOSED AT AUTOPSY* 20 EXTERNAL BEAM, NOS 21 ORTHOVOLTAGE 22 COBALT-60, CESIUM-137 23 PHOTONS (2-5 MV) 24 PHOTONS (6-10 MV) 25 PHOTONS (11-19 MV) 26 PHOTONS (>19 MV) 27 PHOTONS (MIXED ENERGIES) 28 ELECTRONS 29 PHOTONS AND ELECTRONS MIXED 30 NEUTRONS, WITH OR WITHOUT PHOTONS/ELECTRONS 31 IMRT 32 CONFORMAL OR 3-D THERAPY 40 PROTONS 41 STEREOTACTIC RADIOSURGERY, NOS 42 LINAC RADIOSURGERY, NOS 43 GAMMA KNIFE 50 BRACHYTHERAPY, NOS 51 BRACHYTHERAPY, INTRACAVIATARY, LDR 52 BRACHYTHERAPY, INTRACAVIATARY, HDR 53 BRACHYTHERAPY, INTERSTITIAL, LDR 54 BRACHYTHERAPY, INTERSTITIAL, HDR 55 RADIUM 60 RADIOISOTOPES, NOS 61 STRONTIUM-89 62 STRONTIUM-90 80 COMBINATION MODALITY, SPECIFIED* 85 COMBINATION MODALITY, NOS 98 OTHER, NOS 99 UNKNOWN; *DEATH CERTIFICATE ONLY*
VI.3.4	Radiation –Boost RX Modality	00 NO BOOST TREATMENT; *DIAGNOSED AT AUTOPSY* 20 EXTERNAL BEAM, NOS 21 ORTHOVOLTAGE 22 COBALT-60, CESIUM-137 23 PHOTONS (2-5 MV) 24 PHOTONS (6-10 MV)

25 PHOTONS (11-19 MV)
26 PHOTONS (>19 MV)
27 PHOTONS (MIXED ENERGIES)
28 ELECTRONS
29 PHOTONS AND ELECTRONS MIXED
30 NEUTRONS, WITH OR WITHOUT PHOTONS/ELECTRONS
31 MRT
32 CONFORMAL OR 3-D THERAPY

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

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

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

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

VI. 3.5 Date of Radiation Therapy

00000000 NO RADIATION THERAPY ADMINISTERED; AUTOPSY-ONLY CASE

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

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

VI.3.6 Reason for No Radiation

0 RADIATION TREATMENT PERFORMED
1 RADIATION TREATMENT NOT PERFORMED BECAUSE IT WAS NOT A PART OF THE PLANNED FIRST COURSE TREATMENT
2 RADIATION CONTRAINDICATED BECAUSE OF OTHER CONDITIONS OR OTHER PATIENT RISK FACTORS (CO-MORBID CONDITIONS, ADVANCED AGE, ETC)
5 RADIATION TREATMENT NOT PERFORMED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED TREATMENT

6	RADIATION TREATMENT WAS RECOMMENDED BUT NOT PERFORMED. NO REASON WAS NOTED IN THE PATIENT'S RECORD.
7	RADIATION TREATMENT WAS RECOMMENDED BUT REFUSED BY THE PATIENT, FAMILY MEMBER OR GUARDIAN. THE REFUSAL IS NOTED IN THE PATIENT'S RECORD.
8	RADIATION RECOMMENDED, UNKNOWN IF DONE
9	UNKNOWN IF RADIATION RECOMMENDED OR PERFORMED; DEATH CERTIFICATE AND AUTOPSY ONLY CASES

VI.3.7 Radiation Sequence With Surgery

0	NOT APPLICABLE; *DIAGNOSED AT AUTOPSY*
2	RADIATION BEFORE SURGERY
3	RADIATION AFTER SURGERY
4	RADIATION BOTH BEFORE AND AFTER SURGERY
5	INTRAOPERATIVE RADIATION
6	INTRAOPERATIVE RADIATION WITH OTHER RADIATION GIVEN BEFORE OR AFTER SURGERY
9	SEQUENCE UNKNOWN, BUT BOTH SURGERY AND RADIATION WERE GIVEN

VI.4 Chemotherapy

00	NONE, CHEMOTHERAPY WAS NOT PART OF THE PLANNED FIRST COURSE OF THERAPY; *DIAGNOSED AT AUTOPSY*
01	CHEMOTHERAPY, NOS.
02	SINGLE AGENT CHEMOTHERAPY
03	MULTIAGENT CHEMOTHERAPY ADMINISTERED AS FIRST COURSE THERAPY
82	CHEMOTHERAPY WAS NOT RECOMMENDED/ADMINISTERED DUE TO CONTRAINDICATIONS.
85	CHEMOTHERAPY NOT ADMINISTERED BECAUSE THE PATIENT DIED.
86	CHEMOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT WAS NOT ADMINISTERED AS PART OF THE FIRST COURSE OF THERAPY. NO REASON WAS STATED IN PATIENT RECORD.
87	CHEMOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT THIS TREATMENT WAS REFUSED BY THE PATIENT, A PATIENT'S FAMILY MEMBER, OR THE PATIENT'S GUARDIAN. THE REFUSAL WAS NOTED IN PATIENT RECORD.
88	CHEMOTHERAPY WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.

	99	IT IS UNKNOWN WHETHER A CHEMOTHERAPEUTIC AGENT(S) WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

VI.4.3 Date of Chemotherapy

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

VI.5.4 Hormone Therapy

00	NONE, HORMONE THERAPY WAS NOT PART OF THE PLANNED FIRST COURSE THERAPY; *DIAGNOSED AT AUTOPSY.*
01	HORMONE THERAPY ADMINISTERED AS FIRST COURSE THERAPY.
82	HORMONE THERAPY WAS NOT RECOMMENDED/ ADMINISTERED BECAUSE IT WAS CONTRAINDICATED DUE TO PATIENT RISK FACTORS (IE, COMORBID CONDITIONS, ADVANCED AGE).
85	HORMONE THERAPY WAS NOT ADMINISTERED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED THERAPY.
86	HORMONE THERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT WAS NOT ADMINISTERED AS PART OF THE FIRST COURSE THERAPY. NO REASON WAS STATED IN PATIENT RECORD.
87	HORMONE THERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT THIS TREATMENT WAS REFUSED BY THE PATIENT, A PATIENT'S FAMILY MEMBER, OR THE PATIENT'S GUARDIAN. THE REFUSAL WAS NOTED IN THE PATIENT RECORD. HORMONE THERAPY WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.
99	IT IS UNKNOWN WHETHER A HORMONAL AGENT(S) WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

VI.5.5 Date Of Hormone Therapy

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

VI.6 Immunotherapy (Biological Response Modifier)

00	NONE, IMMUNOTHERAPY WAS NOT PART OF PART OF THE PLANNED FIRST COURSE OF THERAPY; *DIAGNOSED AT AUTOPSY.*
01	IMMUNOTHERAPY ADMINISTERED AS FIRST COURSE THERAPY
82	IMMUNOTHERAPY WAS NOT RECOMMENDED/ADMINISTERED BECAUSE IT WAS CONTRAINDICATED DUE TO PATIENT RISK FACTORS (i.e. COMORBID CONDITIONS, ADVANCED AGE).
85	IMMUNOTHERAPY WAS NOT ADMINISTERED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED THERAPY.
86	IMMUNOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT WAS NOT ADMINISTERED AS PART OF THE FIRST COURSE OF THERAPY. NO REASON WAS STATED IN PATIENT RECORD.
87	IMMUNOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT THIS TREATMENT WAS REFUSED BY THE PATIENT, A PATIENT'S FAMILY MEMBER, OR THE PATIENT'S GUARDIAN. THE REFUSAL WAS NOTED IN THE PATIENT RECORD.
88	IMMUNOTHERAPY WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.
99	IT IS UNKNOWN WHETHER AN IMMUNOTHERAPEUTIC AGENT(S) WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

VI.6.3 Date of Immunotherapy

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

VI.7 Transplant/ Endocrine Procedures

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

88	HEMATOLOGIC TRANSPLANT AND/OR ENDOCRINE SURGERY/RADIATION WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.
99	IT IS UNKNOWN WHETHER HEMATOLOGIC TRANSPLANT AND/OR ENDOCRINE SURGERY/ RADIATION WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

VI.7.2 Date of Transplant/Endocrine Procedure

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

VI.8 Other Therapy

0	NO OTHER CANCER DIRECTED THERAPY EXCEPT AS CODED ELSEWHERE; *DIAGNOSED AT AUTOPSY.*
1	OTHER CANCER DIRECTED THERAPY
2	OTHER EXPERIMENTAL CANCER DIRECTED THERAPY (not included elsewhere)
3	DOUBLE BLIND CLINICAL TRIAL, CODE NOT YET BROKEN
6	UNPROVEN THERAPY
7	PATIENT OR PATIENT'S GUARDIAN REFUSED THERAPY WHICH WOULD HAVE BEEN CODED 1–3 ABOVE
8	OTHER CANCER DIRECTED THERAPY RECOMMENDED, UNKNOWN IF ADMINISTERED
9	UNKNOWN IF OTHER THERAPY RECOMMENDED OR ADMINISTERED; *DEATH CERTIFICATE ONLY*

VI.8.2 Date of Other Therapy

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

VI.9 Protocol Participation.

00	Not Applicable
National Protocols	
01	NSABP
02	GOG
03	RTOG
04	SWOG
05	ECOG
06	POG
07	CCG
08	CALGB
09	NCI
10	ACS
11	National Protocol, NOS
12	ACOS-OG
13	VA [Veterans Administration]
14	COG [Children's Oncology Group]
15	CTSU [Clinical Trials Support Unit]
16-50	National Trials
51-79	Locally Defined
80	Pharmaceutical
81-84	Locally Defined
85	In-House Trial
86-88	Locally Defined
89	Other
90-98	Locally Defined
99	Unknown

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

FOLLOW-UP

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

CERVIX UTERI

C53.0-C53.9

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

For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Loop Electrocautery Excision Procedure (LEEP)
- 16 Laser ablation
- 17 Thermal ablation

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

20 Local tumor excision, NOS
- 26 Excisional biopsy, NOS
- 27 Cone biopsy
- 24 Cone biopsy WITH gross excision of lesion
- 29 Trachelectomy; removal of cervical stump; cervicectomy

Any combination of 20, 24, 26, 27 or 29 WITH
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision

- 25 Dilatation and curettage; endocervical curettage (for in situ only)
- 28 Loop electrocautery excision procedure (LEEP)

Specimen sent to pathology from surgical events 20-29.

30 Total hysterectomy (simple, pan-) WITHOUT removal of tubes and ovaries
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

40 Total hysterectomy (simple, pan-) WITH removal of tubes and/or ovary
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

- 50 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 51 Modified radical hysterectomy
- 52 Extended hysterectomy
- 53 Radical hysterectomy; Wertheim procedure
- 54 Extended radical hysterectomy

CERVIX UTERI

C53.0-C53.9

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

60 Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries
- 61 WITHOUT removal of tubes and ovaries
- 62 WITH removal of tubes and ovaries

70 Pelvic exenteration
- 71 Anterior exenteration

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

NOTE*: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.*

72 Posterior exenteration

Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

NOTE: *Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.*

73 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes.

NOTE: *Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.*

74 Extended exenteration

Includes pelvic blood vessels or bony pelvis.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

CORPUS UTERI

C54.0-C55.9

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

For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350).

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Loop Electocautery Excision Procedure (LEEP)
- 16 Thermal ablation

No specimen sent to pathology from surgical events 10-16.

20 Local tumor excision, NOS; simple excision, NOS
- 24 Excisional biopsy
- 25 Polypectomy
- 26 Myomectomy

Any combination of 20 or 24-26 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision

Specimen sent to pathology from surgical events 20-26.
[Margins of resection may have microscopic involvement]
[SEER Guideline: Procedures in code 20 include but are not limited to: cryosurgery, electrocautery, excisional biopsy, laser ablation, thermal ablation]

30 Subtotal hysterectomy/supracervical hysterectomy/fundectomy WITH or WITHOUT removal of tube(s) and ovary(ies).
- 31 WITHOUT tube(s) and ovary(ies)
- 32 WITH tube(s) and ovary(ies)

[SEER Guideline: for these procedures, the cervix is left in place]

CORPUS UTERI

C54.0-C55.9

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

40 Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

50 Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

60 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 61 Modified radical hysterectomy
- 62 Extended hysterectomy
- 63 Radical hysterectomy; Wertheim procedure
- 64 Extended radical hysterectomy

65 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies) [formerly SEER code 70]
- 66 WITHOUT removal of tube(s) and ovary(ies) [formerly SEER code 71]
- 67 WITH removal of tube(s) and ovary(ies) [formerly SEER code 72]

75 Pelvic exenteration[formerly SEER code 80]
- 76 Anterior exenteration [formerly SEER code 81]

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.
NOTE: *Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.*

77 Posterior exenteration [formerly SEER code 82]0
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.
NOTE: *Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.*

78 Total exenteration [formerly SEER code 83]
Includes removal of all pelvic contents and pelvic lymph nodes.
NOTE: *Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.*

79 Extended exenteration [formerly SEER code 84]
Includes pelvic blood vessels or bony pelvis.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

OVARY
C56.9

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

Codes

00 None; no surgery of primary site; autopsy ONLY

17 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 17.

25 Total removal of tumor or (single) ovary, NOS
- 26 Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
- 27 WITHOUT hysterectomy
- 28 WITH hysterectomy

Specimen sent to pathology from surgical events 25-28.

35 Unilateral (salpingo-)oophorectomy; unknown if hysterectomy done [formerly SEER code 14]
- 36 WITHOUT hysterectomy [formerly SEER code 15]
- 37 WITH hysterectomy [formerly SEER code 16]

50 Bilateral (salpingo-)oophorectomy; unknown if hysterectomy done [formerly SEER code 20]
- 51 WITHOUT hysterectomy [formerly SEER code 21]
- 52 WITH hysterectomy [formerly SEER code 22]

55 Unilateral or bilateral (salpingo-)oophorectomy WITH OMENTECTOMY, NOS; partial or total; unknown if hysterectomy done [formerly SEER code 30]
- 56 WITHOUT hysterectomy [formerly SEER code 31]
- 57 WITH hysterectomy [formerly SEER code 32]

60 Debulking; cytoreductive surgery, NOS
- 61 WITH colon (including appendix) and/or small intestine resection (not incidental)
- 62 WITH partial resection of urinary tract (not incidental)
- 63 Combination of 61 and 62

Debulking is a partial or total removal of the tumor mass and can involve the removal of multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may or may not identify ovarian tissue. A debulking is usually followed by another treatment modality such as chemotherapy.

70 Pelvic exenteration, NOS
- 71 Anterior *exenteration*

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.
NOTE: *Do not code removal of pelvic lymph nodes under Surgical Procedure/OtherSite.*

OVARY
C56.9

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

72 Posterior *extenteration*
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.
NOTE*: Do not code removal of pelvic lymph nodes Surgical Procedure/Other Site.*

73 Total *extenteration*
Includes removal of all pelvic contents and pelvic lymph nodes.
NOTE: *Do not code removal of pelvic lymph nodes Surgical Procedure/Other Site.*

74 Extended *extenteration*
Includes pelvic blood vessels or bony pelvis.
NOTE*: Do not code removal of pelvic lymph nodes Surgical Procedure/Other Site.*

80 (Salpingo-)oophorectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

TESTIS

C62.0-C62.9

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

Codes

00 None; no surgery of primary site; autopsy ONLY

12 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 12.

20 Local or partial excision of testicle [formerly SEER code 10]
Specimen sent to pathology from surgical event 20.

30 Excision of testicle, WITHOUT cord

40 Excision of testicle, WITH cord or cord not mentioned *(radical orchiectomy)*

80 Orchiectomy, NOS (unspecified whether partial or total testicle removed)

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

KIDNEY, RENAL PELVIS, AND URETER

Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

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

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Thermal ablation

No specimen sent to pathology from this surgical event 10-15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

Specimen sent to pathology from surgical events 20-27.

30 Partial or subtotal nephrectomy (kidney or renal pelvis) or partial ureterectomy (ureter)

Procedures coded 30 include, but are not limited to:
- Segmental resection
- Wedge resection

40 Complete/total/simple nephrectomy---for kidney parenchyma
Nephroureterectomy
Includes bladder cuff for renal pelvis or ureter.

50 Radical nephrectomy
May include removal of a portion of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial/total ureter.

BLADDER

C67.0-C67.9

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

70 Pelvic exenteration, NOS

71 Radical cystectomy (female only); anterior exenteration

A radical cystectomy in a female includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra.

72 Posterior exenteration

73 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes.

The lymph node dissection should also be coded under Scope of Lymph Node Surgery (NAACCR Item #1292) or Scope of Regional Lymph Node Surgery at This Hospital (NAACCR Item #672).

74 Extended exenteration

Includes pelvic blood vessels or bony pelvis.

80 Cystectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

BRAIN

Meninges C70.0-C70.9, Brain C71.0-C71.9, Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System C72.0-C72.9

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

Do not code laminectomies for spinal cord primaries.

Codes

00 None; no surgery of primary site; autopsy ONLY

10 [Local]Tumor destruction, NOS
No specimen sent to pathology from surgical event 10.

Do not record stereotactic radiosurgery as tumor destruction. It should be recorded in the radiation treatment item *Regional Treatment Modality* (NAACCR Item # 1570).

20 *Local excision (biopsy)* of tumor, lesion, or mass
Specimen sent to pathology from surgical event 20.

40 Partial resection [NOS]

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

ALL OTHER SITES

***C14.2*-C14.8, C17.0-C17.9, C23.9, C24.0-C24.9, C26.0-C26.9, C30.0-C 30.1, C31.0-C31.9, C33.9, C37.9, C38.0-C38.8, C39.0-C39.9, C48.0-C48.8, C51.0-C51.9, C52.9, C57.0-C57.9, C58.9, C60.0-C 60.9, C63.0-C63.9, C68.0-C68.9, C69.0-C69.9, C74.0-C74.9, C75.0-C75.9**

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

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

Specimen sent to pathology from surgical events 20-27.

30 Simple/partial surgical removal of primary site

40 Total surgical removal of primary site; enucleation
- 41 Total enucleation (for eye surgery only)

50 Surgery stated to be “debulking”

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs.
[SEER Guideline: in continuity with or “en bloc” means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

UNKNOWN AND ILL-DEFINED PRIMARY SITES

C76.0-C76.8, C80.9

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

Code

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

Surgical procedures for unknown and ill-defined primaries are to be recorded using the data item Surgical Procedure/Other Site (NAACCR Item #1294) *or Surgical Procedure/Other Site at This Hospital (NAACCR Item #647).*

[99 Death certificate only]

Data Items and Their Required Status

Item Name	Manual	C/N	RX Ctr	Transmitted from Hospital to Region	SEER Collect	ACoS
CS Metastasis at Diagnosis	V.4.2	yes	yes	yes	yes	yes
CS Metastasis Evaluation	V.4.2	yes*	yes*	yes*	no	yes
CS Site Specific Factor 1	V.4.2	yes	yes	yes	yes	yes
CS Site Specific Factor 2	V.4.2	yes	yes	yes	yes	yes
CS Site Specific Factor 3	V.4.2	yes	yes	yes	yes	yes
CS Site Specific Factor 4	V.4.2	yes	yes	yes	yes	yes
CS Site Specific Factor 5	V.4.2	yes	yes	yes	yes	yes
CS Site Specific Factor 6	V.4.2	yes	yes	yes	yes	yes
CS Version 1st	V.4.2	yes	yes	yes	yes	yes
CS Version Latest	V.4.2	yes	yes	yes	yes	yes
Date of Chemotherapy	VI.1.3.2	sel	sel	yes*	no	no
Date of Diagnosis	III.3.3	yes	yes	yes	yes	yes
Date of First Admission	III.3.1	yes	yes	yes	no	yes
Date of Inpatient Admission	III.3.2	yes*	no	yes*	no	no
Date of Inpatient Discharge	III.3.2	yes*	no	yes*	no	no
Date of Hormone Therapy	VI.1.3.2	sel	sel	yes*	no	no
Date of Immunotherapy	VI.1.3.2	sel	sel	yes*	no	no
Date of Last Patient Contact or Death	VII.2.1	yes	yes	yes	yes	yes
Date of Last Tumor Status	VII.2.3	yes	yes	yes	no	no
Derived AJCC T	V.4.2	yes	yes	yes	yes	yes
Derived AJCC T Descriptor	V.4.2	yes*	yes*	yes*	no	yes
Derived AJCC N	V.4.2	yes	yes	yes	yes	yes
Derived AJCC N Descriptor	V.4.2	yes*	yes*	yes*	no	yes
Derived AJCC M	V.4.2	yes	yes	yes	yes	yes
Derived AJCC M Descriptor	*V.4.2*	*yes**	*yes**	*yes**	*no*	*yes*
Derived AJCC Stage Group	V.4.2	yes	yes	yes	yes	yes
Derived SS2000	V.4.2	yes	yes	yes	yes	yes
Derived SS1977	V.4.2	yes	yes	yes	yes	yes
Derived AJCC - Flag	V.4.2	yes	yes	yes	yes	yes
Derived SS2000 - Flag	V.4.2	yes	yes	yes	yes	yes
Derived SS1977 - Flag	V.4.2	yes	yes	yes	yes	yes

Data Items and Their Required Status

Item Name	Manual	C/N	RX Ctr	Transmitted from Hospital to Region	SEER Collect	ACoS
Date of Most Definitive Surgery of the Primary Site	VI.2.5	gen	gen	yes*	no	yes
Date of Other Therapy	VI.1.3.2	sel	sel	yes*	no	yes
Date of Radiation	VI.1.3.2	sel	sel	yes*	no	yes
Date of Systemic Therapy	VI.1.3.2	gen	gen	yes*	no	yes
Date of Surgery	VI.1.3.2	gen	gen	yes*	no	yes
Date of Surgery– Diagnostic or Staging Procedures	VI.2.12	sel	sel	yes*	no	yes
Date of Surgery– Procedures 1-3	VI.2.5	sel	sel	yes	no	no
Date of Therapy	Vol III	no	no	no	yes	yes
Date of Transplant/Endocrine Procedures	VI.7.2	sel	sel	yes*	no	no
Death File Number	VII.2.14	may	no	no	no	no
Diagnostic Confirmation	IV.2	yes	yes	yes	yes	yes
EOD – Extension	V.4	yes	yes	yes	yes	no
EOD – Extension (Path)	V.4	yes	yes	yes	yes	no
EOD –- Lymph Node Involvement	V.4	yes	yes	yes	yes	no
First Name	III.2.1.2	yes	yes	yes	yes	yes
Follow up Contact Address–Other	VII.3	yes*	yes*	yes	yes	no
Follow up Contact Address–Other - Supplemental	VII.3	yes*	yes*	yes*	no	no
Follow up Contact City–Other	VII.3	yes*	yes*	yes	yes	no
Follow up Contact Name–Other	VII.3	yes*	yes*	yes	yes	no
Follow up Contact State–Other	VII.3	yes*	yes*	yes	yes	no
Follow up Contact Zip–Other	VII.3	yes*	yes*	yes	yes	no
Follow up–Last Type (Patient)	VII.2.6.2	yes	yes	yes	no	no
Follow up–Last Type (Tumor)	VII.2.6.1	yes	yes	yes	no	no
Follow up–Next Type	VII.2.8	yes*	yes*	yes*	no	no
Follow up Hospital (Next)	VII.2.9	yes*	no	no	no	yes
Follow up Hospital (Last)	VII.2.7	yes	yes	yes	no	no
Histology Text	IV.1.7	yes	yes	yes	yes	no
Histology–Behavior (ICD-O-2)	V.3.4	yes	yes	yes	yes	no
Histology–-Behavior (ICD-O-3)	V.3.4	yes	yes	yes	yes	yes
Histology–Grade/ Differentiation	V.3.5	yes	yes	yes	yes	yes
Histology–Type (ICD-O-2)	V.3	yes	yes	yes	yes	no
Histology–-Type (ICD-O-3)	V.3	yes	yes	yes	yes	yes
Hormone Therapy at This Hospital	VI.5	yes	yes	yes	yes	yes
Hormone Therapy Summary	VI.5	yes	yes	yes	yes	yes