Kentucky Cancer Registry

2015 Abstractor's Manual

For use with CPDMS.net

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Introduction

INTRODUCTION

The Cancer Patient Data Management System (CPDMS.net) is a comprehensive, web-based application for collecting, managing and analyzing information related to the diagnosis and treatment of cancer patients in Kentucky. CPDMS.net was developed by the Kentucky Cancer Registry (KCR) to provide individual hospitals with the ability to monitor the type of cancer patients seen in the hospital, the extent of disease at diagnosis, the type of diagnostic procedures used and the type of therapy provided. CPDMS.net enables hospital registries to follow cancer patients over time. Data on all known medical intervention and the health status of each patient can be periodically recorded using CPDMS.net. These data allow individual hospitals to examine both the use of various diagnostic and therapeutic resources as well as the potential effect of these resources on patient survival.

CPDMS.net is designed for independent and autonomous use by individual health care facilities. However, a central repository of data on all cancer patients diagnosed and treated in Kentucky has been established in the Kentucky Cancer Registry. This central data base allows for the calculation and publication of cancer incidence rates for the entire state of Kentucky, as well as for smaller geographic regions within the state.

CPDMS.net includes complete documentation. This abstractor's manual describes each data item which will be collected and precise instruction regarding how the information is to be coded. Mandatory data items are identified by using all UPPER CASE letters in the variable name. Optional items are shown in upper and lower case letters in the item's name. A list of all of the data items in CPDMS.net may be obtained here. The KCR website also contains a printable copy of the abstract form (CPDMS.net Abstract Form 2014.xlsx). On the form, mandatory items are in bold faced type. In addition, a CPDMS.net operator's manual has been developed. The operator's manual contains step-by-step instructions for performing each function of this registry software.

CPDMS.net is a valuable tool for any hospital wishing to develop and maintain a high quality cancer care program. The application meets all of the requirements for an American College of Surgeons approved cancer program and all of the requirements for the National Cancer Institute’s SEER Program. Regional coordinators are available through the KCR to assist hospitals using CPDMS.net in setting up their registry, training personnel, abstracting data and analyzing the information.

COMPUTERIZED RECORD STRUCTURE

CPDMS.net is a fully relational database designed in a modular fashion. Each patient record has a unique identification number internally generated by the computer which links all information stored about that patient. Patient identification information occurs only once in the patient record.

Attached to the patient record is a file containing ten optional, user-defined fields for patient level data.

Each patient may have more than one primary malignancy, or case. These are identified by the primary sequence number and site group code. Those cases which are reportable by your hospital will also have segments of the record containing diagnosis and staging information, as well as follow up data. These data items will occur only once in a case record.

Attached to the case record are segments containing therapy and open text data. The therapy segments may be repeated as often as necessary to record all the appropriate information about a case. Additionally, there are record segments which contain hospital-specific identifiers for each case. Twenty optional, user-defined fields are available for each case record.

For further information regarding CPDMS.net, please refer to the Operator's Manual.

CASE REPORTING REQUIREMENTS

CASES TO BE REPORTED:

All cases of primary malignant disease diagnosed or treated at a Kentucky health care facility on or after January 1, 1991, should be reported to the Kentucky Cancer Registry (KCR). These are usually described by the terms: carcinoma, sarcoma, melanoma, leukemia, or lymphoma. Reportable cases may be identified by specified ICD-9-CM codes. Refer to Casefinding for a list of these codes. They may also be classified by ICD-O topography, morphology, and behavior codes. Effective with diagnoses in 2010, all hematopoietic and lymphoid neoplasms classified with a behavior code 3 in the "WHO Classification of Tumours of Haematopoietic and Lymphoid Tissues" are reportable. These fall into the histology code range of 9590/3 - 9992/3. Only in-situ and malignant neoplasms are reportable (behavior codes 2 and 3); benign, borderline, and metastatic tumors are not reportable to the KCR, except as noted below. However, if a term is used which usually has a behavior code of '0' or '1', but is verified by a pathologist as in-situ or malignant (behavior code 2 or 3), these cases are reportable.

THE ONLY EXCEPTIONS to this are:

- Neoplasms of the skin (ICD-O Topography codes C44.0 to C44.9) with the following ICD-O Morphology codes are NOT reportable:

M 8000-8005 Neoplasms, NOS
M 8010-8046 Epithelial neoplasms
M 8050-8084 Squamous cell neoplasms of the skin
M 8090-8110 Basal cell neoplasms of the skin

NOTE: Localized basal and squamous cell skin cancers greater than 5 cm at diagnosis, as well as those diagnosed at a regional or distant stage, were previously required by ACoS for approved hospitals prior to 2003. **They are not required to be reported to KCR or to ACoS after January 1, 2003.**

- Cases of intraepithelial neoplasia, Grade III, of the cervix or prostate (M-8077/2). These are often designated by terms such as CIN III or PIN III. These cases are not required to be abstracted or reported.
- Any carcinoma in-situ of the cervix is not to be reported to KCR, as of January 1, 1998. This includes any type of malignancy with a topography code of C53 and a behavior code of 2.
- Pilocytic astrocytoma (C71.__, M-9421/1) is required to be reported as a malignant brain tumor with 9421/3.
- As of January 1, 2004, the following non-malignant primary intracranial and central nervous system tumors with a behavior code of /0 or /1 (benign and borderline, or "non-malignant") are required to be reported, regardless of histologic type, for these ICD-O-3 topography codes.

Table 1. Topography Codes for Benign Brain Tumors

Code	Description
	Meninges
C70.0	Cerebral meninges
C70.1	Spinal meninges
C70.9	Meninges, NOS
	Brain
C71.0	Cerebrum
C71.1	Frontal lobe
C71.2	Temporal lobe
C71.3	Parietal lobe
C71.4	Occipital lobe
C71.5	Ventricle, NOS
C71.6	Cerebellum, NOS
C71.7	Brain stem
C71.8	Overlapping lesion of brain
C71.9	Brain, NOS
	Spinal Cord, Cranial Nerves, and Other Parts of the Central Nervous System
C72.0	Spinal cord
C72.1	Cauda equina
C72.2	Olfactory nerve
C72.3	Optic nerve
C72.4	Acoustic nerve
C72.5	Cranial nerve, NOS
C72.8	Overlapping lesion of brain and central nervous system
C72.9	Nervous system, NOS
	Other endocrine glands and related structures
C75.1	Pituitary gland
C75.2	Craniopharyngeal duct
C75.3	Pineal gland

NOTE: Benign and borderline tumors of cranial bones (C41.0) are not reportable.

NOTE: For non-malignant primary intracranial and central nervous system tumors (C70.0 - C72.9, C75.1 - C75.3), the terms "tumor" and "neoplasm" are considered diagnostic for the purpose of case reporting, in addition to the terms generally applicable to malignant tumors.

PATIENTS TO BE REPORTED:

All patients first seen and/or treated at each Kentucky hospital after January 1, 1991 for a diagnosis of cancer should be reported to the Kentucky Cancer Registry. This includes inpatient admissions and patients seen in ambulatory care settings that are hospital affiliated. It includes all clinical diagnoses of cancer, whether histologically confirmed or not. It also includes patients diagnosed as autopsy.

As of January 1, 1995, all patients seen or treated in any licensed health facility in the state, which provides diagnostic or treatment services to cancer patients, shall report cases to the Kentucky Cancer Registry. Physicians in private practice should report any cases of cancer diagnosed or treated in their offices which are not otherwise reported to KCR by another health care facility.

PATIENTS NOT REQUIRED TO BE REPORTED BY HOSPITALS:

1. Patients who are seen only in consultation to confirm a cancer diagnosis or treatment plan, and no treatment was provided by your facility.

EXAMPLE: Patient comes to your institution for a second opinion. Staff physicians order diagnostic tests. The physicians support the original treatment plan. Patient returns to the other institution for treatment.

2. Patients who receive transient care to avoid interrupting a course of therapy initiated elsewhere, for example, while vacationing, or because of equipment failure at the original hospital.

3. Patients whose medical chart indicates a history of cancer only, and who were diagnosed prior to 1991.

4. Patients with in-situ or localized neoplasms of the skin (as listed above).

5. Patients with preinvasive neoplasia of the cervix (as listed above).

TIME FRAME FOR REPORTING:

Cases must be reported to the KCR within 6 months from the date of initial diagnosis or date first seen at the reporting facility if not diagnosed there. For those patients seen on an outpatient basis only, the outpatient visit date is considered the date of discharge.

CLASSES OF CASE:

The class of case codes as defined by the American College of Surgeons in their Facility Oncology Registry Data Standards (FORDS) manual, describe categories (or classes) of cases based on the facility's role in managing the cancer, whether the cancer is required to be reported, and whether the case was diagnosed after the program's reference date. The reporting

requirements of the Kentucky Cancer Registry may differ from those of the American College of Surgeons. For a discussion of ACoS requirements, refer to the FORDS manual.

Class of Case divides cases into two groups. Analytic cases (codes 00–22) are those that are required by CoC to be abstracted because of the program's primary responsibility in managing the cancer. Nonanalytic cases (codes 30–49 and 99) may be abstracted by the facility to meet central registry requirements or in response to a request by the facility's cancer program.

KCR requires all analytic cases (class 00-22) as well as autopsy only cases (class 38) to be fully abstracted and reported to KCR. In addition, cases of VIN, VAIN, and AIN (8077/2), though not required by COC, are required to be reported to SEER and KCR. Therefore, these cases should be coded in the analytic classes (00-22) rather than 34 or 36. They will automatically be excluded from transmission to NCDB by CPDMS.net. KCR also requires information about non-analytic cases (class 32 and 40-43) to be reported to KCR. See Section below: INFORMATION TO BE REPORTED TO KCR.

In the 2010 class of case conversion, skin cancers which were reportable prior to 2003 and CIN/CIS of the cervix diagnosed prior to 1998 are converted to class 34 or 36, as applicable. See Class of Case (item #30140) for a comprehensive list of all classes of cases.

INFORMATION TO BE REPORTED TO KCR:

Cases in classes 00-22 and 38 must be fully abstracted in CPDMS.net. All mandatory data elements must be filled in. Detailed instructions for completing the Abstract Form can be found in this manual.

These cases must also be followed annually throughout the life of the patient. A comprehensive method to identify and track patients must be implemented by the reporting hospital. The follow up information that is required to be reported is detailed in items 31750 - 32060. The only exceptions to the follow up requirements are patients residing in foreign countries and patients with carcinoma in situ of the cervix. These two categories of patients are not required to be followed, regardless of class of case. The ACoS does not require CoC approved hospitals to follow patients over 100 years of age. However, KCR requires Kentucky hospitals to follow **all** patients in classes 00-22, regardless of age.

Cases diagnosed prior to January 1, 2000, which are class 32 (formerly class 3 before 2010) must be reported to KCR. Effective with year 2000 diagnoses, registries have a choice in reporting class 32 cases to KCR. Facilities may choose to continue abstracting these cases, or instead they may send the case information to KCR to be abstracted. If your registry chooses to forward the case to KCR, you are still required to send all applicable case information to KCR in a timely manner!

Cases in class 37 (formerly class 4 prior to 2010) are not required to be reported to the Kentucky Cancer Registry. Abstracting the case and lifetime follow up are entirely optional.

Cases in class 49 (formerly class 8 prior to 2010) are those discovered through death certificate files only. KCR staff will abstract these cases. Class 49 is only for use by the central registry.

Cases in class 99 (formerly class 9 prior to 2010) are nonhospital facility cases. Class 99 is only for use by the central registry. NOTE: If your hospital has read an outside pathology report diagnosing cancer, this is not reportable by your facility. However, information regarding the diagnosis MUST be sent to KCR so that the case may be abstracted by nonhospital facility staff.

THERAPY - FIRST AND SUBSEQUENT COURSE

First course of therapy includes any and all procedures or treatments planned by the managing physician(s), and administered during or after the first clinical diagnosis of cancer. Treatment usually modifies, controls, removes, or destroys proliferating cancer tissue, whether primary or metastatic, regardless of the patient's response. First course may include multiple modes of therapy, and may encompass intervals of a year or more.

No therapy is a treatment option that occurs if the patient or family refuses treatment, or the patient dies before treatment starts, or the physician recommends "watchful waiting" or no treatment be given.

When a treatment plan is not available, evaluate the therapy and the time it started. If the therapy is a part of an established protocol or within accepted management guidelines for the disease, it is first course of therapy. Consult the attending physician or registry's physician advisor if protocols or management guidelines are not available.

If there is no treatment plan, established protocol, or management guidelines, and you cannot consult with a physician, use the principle: "initial treatment must begin within four months of the date of initial diagnosis." All other cancer-directed therapy that <u>begins</u> within four months of the date of the initial treatment would be first course of therapy.

TIME FRAME FOR REPORTING FOLLOW-UP INFORMATION:

Current follow-up information must be reported to KCR for every case diagnosed since 1995 that is class 00-22. Follow-up information is considered current if the date of last contact with the patient is within 15 months of the current date. CPDMS.net can generate reports which identify patients who require updated follow-up information.

CASEFINDING

All participating institutions should establish procedures for complete casefinding within their institution. In many hospitals, records are housed in one location (i.e., the medical records department). In others, procedures for identifying patients from multiple independent ancillary service areas may be necessary (i.e., outpatient clinics, radiation therapy, etc). It is important that the following multiple sources in the hospital be searched to keep missed reportable cases to a minimum. The procedures outlined below should be adapted to each individual hospital.

1. Medical record disease discharge diagnostic index:

Any patient record coded with the diagnoses listed below should be reviewed to determine if the case is one which meets KCR reportability criteria. Note that a diagnosis is not necessarily reportable simply because it falls within the codes below; refer to the Case Reportability Requirements to make sure the case is truly reportable to KCR.

ICD-9-CM Casefinding List for Reportable Tumors (Effective Date: 10/01/2014 to 09/30/2015)

ICD-9-CM	Explanation of Code
140.0 - 172.9	Malignant neoplasms
173.00	Unspecified malignant neoplasm of skin of lip
173.09	Other specified malignant neoplasm of skin of lip
173.19	Other specified malignant neoplasm of skin of eyelid
173.29	Other specified malignant neoplasm of skin of ear
173.39	Other specified malignant neoplasm of skin of face
173.49	Other specified malignant neoplasm of skin of scalp
173.59	Other specified malignant neoplasm of skin of trunk
173.69	Other specified malignant neoplasm of skin of arm
173.79	Other specified malignant neoplasm of skin of leg
173.89	Other specified malignant neoplasm of skin of other
173.99	Other specified malignant neoplasm of skin NOS
174.0 - 209.36	Malignant neoplasms
209.70 -	Secondary neuroendocrine tumors
225.0 - 225.9	Benign neoplasm of brain and spinal cord neoplasm
227.3 - 227.4	Benign neoplasm of pituitary gland, craniopharyngeal duct (pouch) and pineal gland
227.9	Benign neoplasm; endocrine gland, site unspecified
228.02	Hemangioma; of intracranial structures

228.1	Lymphangioma, any site
230.0 - 234.9	Carcinoma in situ
236.0	Endometrial stroma, low grade
237.0 - 237.9	Neoplasm of uncertain behavior (borderline) of endocrine glands and nervous system
238.4	Polycythemia vera
238.6 - 238.79	Other lymphatic and hematopoietic diseases
239.6 - 239.89	Neoplasms of unspecified nature
273.2	Other paraproteinemias
273.3	Macroglobulinemia
288.3	Eosinophilia
288.4	Hemophagocytic syndromes
795.06	Pap smear of cervix with cytologic evidence of malignancy
795.16	Pap smear of vagina with cytologic evidence of malignancy
796.76	Pap smear of anus with cytologic evidence of malignancy
V10.0 -	Personal history of malignancy
V12.41	Personal history of benign neoplasm of the brain

This procedure is imperative to assure that no cases have been missed, including those originally diagnosed by clinical methods only. A list of supplemental ICD-9-CM codes effective 10/01/2014 thru 09/30/2015 which may also be used for casefinding is available in APPENDIX M .

Follow this link for a casefinding list of reportable ICD-10 codes effective 10/01/2014, or whenever a hospital adopts ICD-10 coding. It also includes a comprehensive list plus a supplemental list. http://www.seer.cancer.gov/tools/casefinding/case2015-icd10cm.html

Follow this link for a casefinding list of reportable ICD-10 codes effective 10/01/2015, which includes a comprehensive list plus a supplemental list. http://seer.cancer.gov/tools/casefinding/case2016-icd10cm.html

2. Pathology reports:

All pathology reports on both inpatients and outpatients should be reviewed for case reportability. Since most cancer patients have a biopsy or operative resection performed, nearly all of the reportable cases can be identified through pathology reports alone. Histologic diagnoses are based upon microscopic examination of tissue taken from such procedures as biopsy, frozen section, surgery, or D & C. Expand path report screening to include benign CNS tumors, beginning with 1-1-04 diagnoses. Check for cases of anal intraepithelial neoplasia, grade

III (AIN III), ductal intraepithelial neoplasia 3 (DIN 3), vaginal intraepithelial neoplasia, grade III (VAIN III), and vulvar intraepithelial neoplasia, grade III (VIN III).

NOTE: Path reports may be the best source for finding cases of VIN, VAIN, and AIN (8077/2) and DIN (8500/2).

3. Cytology reports:

All cytology reports for both inpatients and outpatients should be reviewed for case reportability. Cytologic diagnoses are based upon microscopic examination of cells as contrasted with tissues. Included are smears from sputum, bronchial bushings, bronchial washings, tracheal washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, and urinary sediment. Cervical and vaginal smears are common examples.

4. Autopsy reports.

5. Radiation Therapy Department logs.

6. Medical Oncology Department logs.

7. Outpatient Department:

New patient registration rosters, clinic appointment books, surgery schedules, diagnostic imaging, and billing departments are additional casefinding sources.

8. Alpha listing of previously included cases:

Casefinding cannot be considered complete until the CPDMS.net accession list and any previous registry accession lists have been checked to be sure that this is a new patient or a new primary.

Creating and Maintaining a Nonreportable List

In the course of routine casefinding activities, cases which are found to be nonreportable by your hospital should be added to a nonreportable list. The list should consist of each patient's name, DOB, SSN, medical record number, the type/site of cancer, and a brief explanation of why the case is not reportable to the hospital registry (i.e., "patient was seen for consult only, no dx or tx," or "patient originally diagnosed prior to reference date"). A well-maintained nonreportable list will save registrars time by preventing them from reviewing a chart multiple times to check on a particular primary that does not need to be abstracted. The list can be invaluable during casefinding audits by allowing quick resolution of possible missed cases. It is also helpful during the death clearance process.

Bear in mind that cases which are not reportable by your hospital, but which **ARE** reportable to KCR (see Case Reporting Requirements) should be sent to the central registry to be abstracted there. These may include:

- A specimen from an outside doctor’s office which was sent to your hospital’s path lab
- Any case that was diagnosed and/or treated only in a nonhospital facility
- A Kentucky resident who was initially diagnosed or treated out of state

GENERAL PRINCIPLES IN CODING

AMBIGUOUS TERMINOLOGY AT DIAGNOSIS

According to the Reporting Requirements, all cases of primary malignant disease diagnosed or treated at a Kentucky hospital on or after January 1, 1991 are required to be included. These are usually described by the terms: carcinomas, sarcomas, melanomas, leukemias, and lymphomas. The primary reference book which lists all malignant diseases is the International Classification of Diseases for Oncology (ICD-O), third edition. In addition to providing a list of all morphologies considered to be malignant (or cancerous), the ICD-O book also contains cell behavior codes: 0=benign, 1=borderline malignancy, 2=in-situ, 3=malignant primary, 6=malignant metastasis, and 9=malignant, unknown if primary or metastatic. All malignancies with a behavior code of 2 or 3 in ICD-O, 3rd edition, should be included in the registry, except specified neoplasms of the skin and preinvasive cervical neoplasia, as described in Case Reporting Requirements. Benign and borderline CNS tumors diagnosed on or after January 1, 2004 are required to be reported.

Other benign tumors and borderline malignancies (behavior codes 0 and 1) may be listed in the registry in a separate accession register. They should not be entered into CPDMS.net. These diagnoses are referred to as "reportable-by-agreement" cases.

Metastatic tumors and tumors that are unknown if primary or metastatic (behavior codes 6 and 9) are indicative of a primary malignancy of an unknown site. These cases should be reported with the primary site coded as "unknown primary" (topography code of C80.9) and the appropriate morphology code with a behavior code of /3.

1. Inconclusive diagnostic terms

   Occasionally the diagnosis contains vague or inconclusive terms, such as probable carcinoma of the lung. The following terms are considered to be diagnostic of cancer if they modify a term such as malignancy or carcinoma:

   apparent(ly)
   appears
   compatible with
   comparable with
   consistent with
   favor(s)
   most likely
   malignant appearing
   most likely
   presumed
   probable
   suspect(ed)

suspicious (for)
typical of

EXCEPTION: If a cytology report says "suspicious," do not interpret it as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology. The diagnosis date is date of supporting documentation - either physician statement or positive biopsy.

If a term does not appear on the above list, or is not a form of a word on this list, the term is not diagnostic of cancer. Do not accession the case. Examples of forms of a word are "favored" rather than "favor(s)" and "appeared to be" rather "appears." Do **not** substitute synonyms such as "supposed" for "presumed" or "equal" for "comparable."

Any other ambiguous terminology regarding the diagnosis of a malignancy is not to be interpreted as diagnostic of cancer. Some examples are:

cannot be ruled out
equivocal
likely
lump
lytic lesion (on x-ray)
mass
neoplasm*
nodule
possible
potentially malignant
questionable
rule out
suggests
tumor*
worrisome

For example, a diagnosis of **probable** carcinoma of the left lung would be abstracted as a lung primary. A **possible** carcinoma is not reportable.

*EXCEPTION: For benign and borderline brain and CNS tumors, the terms "tumor" and "neoplasm" will be considered diagnostic of a reportable disease.

2. Changing the diagnosis

Over time, information may be added to the patient's medical chart that was missing or ambiguous in the original record. It is the practice to accept the thinking and information about the case based on the latest or most complete information. Thus, it is acceptable to change the primary site and histology as

information becomes more complete. However, information about the Collaborative Stage and extent of disease at diagnosis may only be changed as long as the new information reflects the time period within four months of the date of diagnosis in the absence of disease progression or through first course surgeries, whichever is longer.

There may be cases reported originally as cancer with the ambiguous terms listed previously, which later information indicates never were malignancies. These cases must be deleted from the file, and the sequence number of any remaining cases for the same person adjusted accordingly.

STAGING SYSTEMS

1. AJCC Staging

The American College of Surgeons (ACoS) Commission on Cancer has required that all approved programs must TNM stage all sites contained in the AJCC *Manual for Staging of Cancer* since January 1, 1991. Effective with 1995 cases, all cancers must be coded for the AJCC staging elements both clinically and pathologically.

> Clinical extent of disease is based on information and evidence accumulated before cancer-directed treatment. It is based on the physical examination, imaging, endoscopy, biopsy, surgical exploration, and other relevant findings. Clinical classification is appropriate for sites accessible for clinical examination. Use clinical classification when an organ does not have a pathologic evaluation.
>
> Pathologic extent of disease is based on information gathered before cancer-directed treatment, as well as evidence gathered from surgery and pathological examination of the resected specimen. Pathologic extent of disease is a combination of all findings through first course of surgery, or 4 months, whichever is longer, in the absence of disease progression.

2. SEER Summary Stage 2000

The Commission on Cancer also requires Summary Staging for any and all sites not included or not appropriate for AJCC TNM staging. The Kentucky Cancer Registry required **Summary Staging 1977 on all cases diagnosed prior to January 1, 2001.** On January 1, 2001, the SEER Summary Stage 2000 coding scheme was implemented. This field will be calculated from the data values entered in the SEER Extent of Disease and Collaborative Stage fields, so it does not have to be manually coded.

> Extent of disease is limited to all information available through completion of first course surgery(ies) or within four months of diagnosis in the absence of disease progression, whichever is longer.
>
> Summary Stage for all sites is based on pathological, operative, and clinical assessments. The priority for using these reports is:
>
> -Pathologic
> -Operative (Particularly important when the surgical procedure does not remove all malignant tissue)
> -Clinical

3. Directly Coded Summary Stage 2000

This field is required in 2015, in addition to the derived Summary Stage 2000 field mentioned above.

4. SEER Extent of Disease (EOD)

For cases diagnosed from January 1, 2000 to December 31, 2003, the Kentucky Cancer Registry requires SEER Extent of Disease coding. Extent of Disease should include all information available through completion of surgery(ies) in first course treatment or within four months of diagnosis in the absence of disease progression, whichever is longer.

For all sites, extent of disease is based on a combined clinical and operative/pathological assessment. Use the SEER Extent of Disease Coding Manual, Third Edition (1998) to determine the code values for these fields.

5. Collaborative Staging

Collaborative Staging (CS) is to be used for cases diagnosed on or after January 1, 2004. It is not to be used for cases diagnosed prior to that date. Its introduction does not affect CoC requirements for physicians to assign AJCC staging or the requirement that the physician-assigned staging values be recorded in the registry.

With Collaborative Staging, registrars code discrete pieces of information once and the CS computer algorithm derives the values for AJCC T, N, M and Stage Group, Summary Stage 1977, and Summary Stage 2000. The derived stage codes are ideally suited for data analysis because of the consistency that can be obtained with objectively-recorded, identically-processed data items.

The timing rule for CS coding was designed to make use of the most complete information possible to yield the "best stage" information for the tumor at the time of diagnosis- "use all information gathered through completion of surgery(ies) in first course of treatment or all information available within four months of the date of diagnosis in the absence of disease progression, whichever is *longer*." Disease progression is defined as further direct extension or distant metastasis known to have developed after the diagnosis was established. Information about tumor extension, lymph node involvement, or distant metastasis obtained after disease progression is documented, should be excluded from the CS coding.

CS data items are coded by the registrar. The CS algorithm produces the output items listed as derived fields. The derived AJCC items are separate from the physician-coded items; and the derived Summary Stage items are separate from the manually-coded items collected by the CoC in the past. The derived items cannot be manually altered.

Like the AJCC and Summary Stage codes that are derived from it, CS is a site-specific staging system. The CS algorithm uses tumor site and histology to determine which CS schema to apply. Depending on the schema, the coding instructions and code definitions will vary. Collaborative Staging codes are defined for every site and histology combination. The AJCC *Cancer Staging*

Manual does not cover all sites, and some histologies are excluded from sites with an AJCC coding scheme. When the CS algorithm processes a site-histology combination that does not have an applicable AJCC code, it assigns the display string "NA" for "Not applicable." A blank display string for a derived item means the CS algorithm was not run for the case.

The complete instructions and site-histology defined codes are available in the *Collaborative Staging Manual and Coding Instructions.* Part I provides general instructions and the instructions and codes for generic (non site-specific) items. Part II contains the site-specific instructions and codes. The *CS Manual* and related information is available electronically on the AJCC Web site at https://cancerstaging.org/cstage/Pages/default.aspx.

FIRST COURSE OF THERAPY

1. Treatment Plan

A treatment plan describes the type(s) of treatment(s) intended to modify or control the malignancy. The documentation confirming a treatment plan may be fragmented. It is frequently found in several different sources, i.e., medical record, clinic record, consultation reports, and outpatient records. All cancer-directed treatments specified in the physician(s) treatment plan are a part of the first course of therapy.

A treatment plan may specify only one method of treatment (i.e., surgery) or any combination of therapies (i.e., surgery, radiation therapy, chemotherapy, hormone therapy, immunotherapy, or other therapy). A single regimen includes the combination of concurrent or adjuvant treatments. All treatments specified in the treatment plan and delivered to the patient are first course of therapy.

2. Time Period

All Malignancies Except Leukemia

First course of therapy includes all cancer-directed treatment planned by the physician(s) during or after the first diagnosis of cancer. Planned treatment may include multiple modes of therapy, and may encompass intervals of a year or more. No treatment may be a planned treatment option; therefore, first course of therapy may be No treatment.

When a treatment plan is not available, evaluate the therapy and the time it started. If the therapy is a part of an established protocol or within accepted management guidelines for the disease, it is first course of therapy.

Consult the attending physician or registry's physician advisor if protocols or management guidelines are not available. If there is no treatment plan, established protocol, or management guidelines, and you cannot consult with a physician, use the principle: "first course treatment must begin within four months of the date of initial diagnosis." Any treatment given after four months is subsequent treatment.

Treatment failure or disease progression may prompt the physician to stop therapy before the full course has been completed. Record any treatments administered after the discontinuation of first course as secondary or subsequent therapy only. If there is no documentation of a treatment plan, a progression, recurrence, or treatment failure, first course ends four months after diagnosis date. Any treatment given after four months is second course treatment in the absence of a documented treatment plan or therapy standard.

Leukemia

Treatment for leukemia is divided into three phases: remission induction, consolidation, and maintenance. Remission induction is initial intensive chemotherapy and/or biological response modifiers. Consolidation is repetitive cycles of chemotherapy and/or irradiation to the brain, given immediately after remission. Maintenance is chemotherapy given for a period of months or even years to maintain remission. Code all therapy that is remission induction, consolidation or maintenance as first course. Do not record treatment that is given after a patient relapses. Some patients do not have a remission. If a patient does not have a remission, record the treatment given in the first attempt to induce a remission. Do not record treatment administered as a change in the original treatment plan.

3. Definitive Treatment

Definitive treatment usually modifies, controls, removes, or destroys proliferating cancer tissue. Treatment may be directed toward either the primary or metastatic sites. Physicians administer the treatment(s) to minimize the size of tumor, or to delay the spread of disease.

NOTE: Only definitive therapy should be included in statistical analyses of treatment. Surgical codes 00-07, and Other treatment code 0 must be excluded. These codes are not considered definitive therapy.

Palliative treatment is treatment that improves the patient’s quality of life by preventing or relieving suffering. Palliative therapy may include definitive treatment procedures as well as non-definitive patient care procedures. **For example:** The patient was diagnosed with stage IV cancer of the prostate with painful bony metastases. The patient starts radiation treatment intended to shrink the tumor in the bone and relieve the intense pain. The radiation treatments are palliative because they relieve the bone pain; the radiation is also first course of therapy because it destroys proliferating cancer tissue. Record any palliative treatment that modifies or destroys cancer tissue as first course therapy.

4. Non-Definitive Treatment (Non-treatment patient care procedures)

Non-definitive treatments prolong the patient's life, make the patient comfortable, or prepare the patient for definitive therapy. These treatments are <u>not</u> tumor directed. They are not meant to reduce the size of the tumor or delay the spread of disease. Non-definitive procedures include diagnostic procedures and supportive care (treatments designed to relieve symptoms and minimize the effects of the cancer). Non-definitive therapies are generally not used in statistical analysis of treatment.

EXAMPLES:

Surgical procedures:
Incisional biopsies

Exploratory procedures with or without biopsies

Supportive care/relieving symptoms:

Palliative care, including surgery, radiation, and chemotherapy for symptom relief only

Pain medication

Oxygen

Antibiotics administered for an associated infection

Transfusions*

Intravenous therapy to maintain fluid or nutritional balance

Laser therapy directed at relieving symptoms

*__NOTE__: Coding Treatment for Hematopoietic Diseases: For many of the newly reportable hematopoietic diseases, the principal treatment is either supportive care, observation, or another type of treatment that does not meet the usual definition that treatment "modifies, controls, removes or destroys proliferating cancer tissue." Such treatments include phlebotomy, transfusions, aspirin, supportive care and observation. In order to document that patients with hematopoietic diseases did have some medical treatment, SEER and the Commission on Cancer have agreed to record these treatments as First Course "Other Treatment" (code 1) for the hematopoietic diseases ONLY. A complete description of the treatment plan should be recorded in the text field for "Other Treatment" on the abstract. For more details, consult the Hematopoietic Database.

FOLLOW-UP POLICY AND PROCEDURES

I. Definition

A. Follow-up of cancer patients is the systematic process of obtaining accurate information at least annually, on the patient's health, vital status, and progression of disease.

Follow-up information is extremely important for the following reasons:

1. To assist in the early identification of the recurrence of a cancer.
2. To assist the physician in getting former cancer patients to return for scheduled treatments and/or checkups.
3. To insure periodic examinations of former cancer patients since they are prone to develop other cancers.
4. To gather information so physicians can review various types of treatment in terms of survival.

B. Follow-up information must be sought on analytic cases only (classes 0, 1, and 2), with the following exceptions:

1. Patients who are currently residing in foreign countries (New in NAACCR)
2. Patients whose only malignancy is carcinoma in situ of the cervix

These are not required to be followed, regardless of the class of the case.

C. Follow-up is considered delinquent by the American College of Surgeons (ACoS) if the information is not successfully obtained and documented within 15 months of the patient's previous date of last contact. A successful follow-up rate of 90% of a hospital's analytic cases is considered in compliance with ACoS standards for an approved Cancer Program. It is best to maintain the highest follow-up rate possible; survival rates and other valuable statistical analyses are heavily dependent on accurate and timely follow-up information.

II. Follow-up information to be collected includes:

A. The date of last contact. This is either the date of death or the most current date the patient was known to be alive.

B. Survival status. This indicates whether the patient is alive (with or without disease) or dead (from causes related or unrelated to cancer).

C. Present address of patient, if different from that originally recorded.

D. Disease Status. This is information about whether the patient was ever disease free, and if so, the start date of the disease free interval.

E. Recurrence information. This includes the date of first recurrence, the type of first recurrence, and the site(s) of first recurrence.

F. Additional treatment received. This includes the type(s) and date(s) of therapy given after the last date of last contact.

G. If dead, cause of death. This includes any autopsy information available on this patient.

H. Method of obtaining follow-up information. This includes any change in the name or address of the primary or alternate contact persons or in the method for pursuing follow-up on the next attempt.

III. Procedures

A. A list of all patients in the tumor registry for whom no contact has been recorded in the last 12 months can be generated using CPDMS.net.
B. All cancer registries, even the smallest, need form letters, particularly to make physician contact. All form letters should be printed on hospital letterhead and should have the correct phone number, including extension, for the staff contact person. Be sure there is ample space to insert names, addresses, and any additional information about the patient on the form. The information request form for physicians requires a great deal of care in design. You must provide adequate information: the full name of the patient, the diagnosis clearly stated, and the date of your latest information. The data items you request must be arranged in a logical sequence and must be easily recorded. If you must secure physician permission to contact a patient, include that request on the form.
C. It is customary in most registries to obtain physician permission to contact patients directly when contact through that physician is not possible. This permission may be obtained in several ways:
    1. Blanket permission may be granted by action of the medical staff.
    2. In some hospitals, blanket permission to contact patients is not granted for any number of reasons. It then becomes necessary to obtain permission on a case by case basis.
D. Follow-up information on all patients named on the follow-up control list should be pursued in an orderly and stepwise fashion:
    1. Pull and review charts or any internal lists which would indicate these patients' vital status and/or disease status.
    2. Identify any patients who have returned to this hospital and record the most current date of last contact. Review these charts for any other follow-up information related to the patient's cancer progression or treatment and update the patient’s record in CPDMS.net.
    3. Send letters to the primary following physician designated for the patients remaining on the list. Labels can be generated by CPDMS.net to the appropriate contact person for each patient needing follow- up.
    4. When letters are returned with current information about your cancer patients, update the patient’s record in CPDMS.net.
    5. If no new information is available, or no response at all is returned, pursue alternate contacts for information about these patients. These may be other physicians, relatives or friends of the patients, or the patients themselves.
    6. If there are any patients remaining on the control list for whom no current information has been located, you may be able to confirm the patient's vital status through various public agencies: The Department of Motor Vehicles, The Department of Vital Statistics, Voters' Registration, Social Security Administration, U.S. Office of Veterans Affairs, U.S. Postal Service, newspapers, etc.
    7. If all leads fail to return any current information, re-contact the patient's original or last known physician before you consider them "lost" to follow-up.
    8. Record all follow-up efforts and the resulting information in the text of the patient’s record.

CHANGES TO THE CPDMS.NET ABSTRACTOR'S MANUAL

A. CHANGES RESULTING FROM IMPLEMENTATION OF THE COC's FORDS MANUAL IN 2003:

Several data items previously required by CoC were deleted in their FORDS Manual, and many new data items were added. CPDMS.net has not deleted any data items with its 2003 release. However, the required new elements have been added. One of these is an ACoS approval flag, which a hospital user may set in order to invoke data entry processes that provide access to and edit checking on all CoC required fields. Otherwise, only KCR data collection requirements will be enforced by the software routines.

The greatest impact of the FORDS Manual is in the collection of therapy information. The site specific surgery codes have been revised significantly since the CoC's 1998 surgery code revisions. Due to ACoS and SEER reporting requirements, KCR will maintain the old data values in the ROADS surgery fields. These will be identified by the acronym 'ROADS' beside the field name and they must be coded for diagnoses prior to 1/1/2003. Three of the new CoC data items - Surgery at Primary Site, Scope of Regional Lymph Node Surgery, and Surgery at Distant Sites - will have the acronym 'FORDS' beside the new field name and they must be coded for diagnoses on or after 1/1/2003. The other ROADS surgery data items will either be discontinued (Surgical Approach, Number of Regional Lymph Nodes Removed, Reconstruction) or converted to generic codes in FORDS, applicable to all sites (Surgical Margins).

There are eight new Radiation Therapy data items required in FORDS. These will be available only to hospitals that set their ACoS flag to 'approved.' These are NOT required by KCR. Finally, there will be new and separate therapy records specifically for non-definitive surgeries, Hormone Therapy, Immunotherapy, and Transplants/Endocrine procedures. The 'Other' therapy codes and definitions will be converted and revised accordingly.

B. CHANGES FOR 2004:

The two most significant changes for 2004 are the implementation of the collaborative staging system and the inclusion of benign and bordering intracranial and CNS tumors in the list of reportable conditions.

C. CHANGES FOR 2005:

The SEER Rx program is now used to categorize systemic treatments as chemotherapy, hormone therapy or immunotherapy. The most significant change is the classification of drugs according to their mechanism of action. These drugs are now coded as chemotherapy:
- cytostatic agents, including monoclonal antibodies (such as Rituxan and Herceptin), growth factor inhibitors (such as Iressa), anti-angiogenesis agents (such as thalidomide, Avastin, and Neovastat)
-anti-metabolites (such as Vidaza and Alimta)

The SEER Rx program used to classify drugs may be found at www.seer.cancer.gov/tools/seerrx.

D. CHANGES FOR 2006

The CoC no longer requires class of case 0 cases to be followed by the registry or AJCC staged by the physician. However, KCR continues to require registries to follow these cases. Four additional comorbidity fields were added and the data item "Systemic Therapy/Surgery Sequence" was added.

E. CHANGES FOR 2007

The SEER 2007 Multiple Primary and Histology Coding rules were implemented effective with cases diagnosed in 2007. These site-specific rules for determining the number of primary malignancies in solid tumors supersede all previous multiple primary rules. (Existing rules for determining the number of primary malignancies for lymphatic and hematopoietic diseases, and for benign and borderline intracranial and CNS tumors, remain in effect.) Along with the new Multiple Primary rules, six additional data items were introduced in 2007: Ambiguous Terminology, Date of Conclusive Diagnosis, Multiplicity Counter, Date of Multiple Tumors, Type of Multiple Tumors, and Managing Physician. Per ACoS requirements, the National Provider Identification (NPI) numbers were initiated in 2007. These are unique 10-digit identifiers for health care providers who bill Medicare (CMS) for services. The NPI data values are stored in the two support files: physician list and institution list. A lookup for NPI numbers is available at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

F. CHANGES FOR 2008

For cases diagnosed in 2008, the CoC considers pathologic staging information to be adequately collected by the CS items, and thus physician-assigned pathologic AJCC staging is no longer required to be collected. Clinical AJCC staging continues to be required for ACoS approved facilities. Collaborative Stage version 01.04.00 was released and is available at http://cancerstaging.org/cstage/Pages/default.aspx. Clarifications regarding the coding of embolization were issued by the CoC, NPCR, and SEER. Chemoembolization, in which tumor blood-flow is blocked by other means and a chemotherapy drug is injected into the tumor, is coded as chemotherapy. Radioembolization, in which tumor blood-flow is blocked and tiny radioactive beads or coils are injected into the tumor, is coded as radiation therapy. When blood flow to the tumor is blocked using other chemicals or materials (such as alcohol or acrylic), without the use of chemotherapy or radiotherapy, code this treatment in the 'Other' therapy field. Pre-surgical embolization of hypervascular tumors using particles, coils, or alcohol is NOT coded as therapy. This type of embolization is performed to make subsequent surgical resection easier, not as cancer-directed therapy.

G. CHANGES FOR 2009

Beginning with 2009 diagnoses, maiden name should be collected, when known. HER2 test results will be recorded for breast cases. Cases which are diagnosed *in utero* will use the actual

date of diagnosis, rather than the date of birth (note: this situation requires an IF15 override). Two additional optional following physician fields were added. The codes 209.0-209.3 and 511.81 were added to the ICD-9-CM casefinding list, and a supplemental list of codes to aid in casefinding was made available as Appendix N.

H. CHANGES FOR 2010

Collaborative Stage version 2.0 was implemented, which entailed a great number of changes and the conversion of CS data elements for all diagnoses from 2004-2009. SSF 7-25 were added at this time. The *AJCC Cancer Staging Manual*, 7th Edition was adopted for coding the T, N, M, and Stage Group fields. The Hematopoietic Database (which includes the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual) was released and replaced all previous coding rules for these malignancies. New histology codes which are not in ICD-O-3 were added to the Histology Support File and the following diseases were changed from borderline to malignant: Langerhans cell histiocytosis (9751/3), T cell large granular lymphocytic leukemia (9831/3), and myeloproliferative neoplasm, unclassifiable (9975/3).

Several new fields were added, including Radiation/Systemic Tx Sequence, Grade Path System, Grade Path Value, Lymph-Vascular Invasion, Treatment Status, Date Case Completed-COC, Surgical Approach 2010, Place of Diagnosis, and Reason No Non-definitive Surgery. Modifications were made to the existing items Race 1-5, Class of Case, Laterality, Diagnostic Confirmation, AJCC Staging, and Radiation Number of Treatments to This Volume.

I. CHANGES FOR 2011

Collaborative Stage version 02.03 was implemented. Cases diagnosed from January 1, 2011 forward were coded using the new version. Version 02.03 introduced one new schema (for myeloma/plasma cell malignancies), added and revised codes, incorporated new algorithms, and revised some coding instructions. It also added the following new SSF's to existing schema: SSF15 for breast, SSF10 for bile duct intrahepatic, and SSF13-16 for testis.

FORDS 2011 requires that comorbidities be coded using ICD-10, upon a facility's transition from ICD-9. Minor revisions were made to the surgery codes for liver, breast, and prostate.

A "Do Not Contact" flag was added as a patient level field so that registries may mark patients who should never be directly contacted.

J. CHANGES FOR 2013

Country codes were added to address current, address at diagnosis, place of birth and place of death. (See new APPENDIX B). Secondary diagnosis 1-10 were added to capture co-morbidities when they are recorded in the medical record using ICD-10 codes. These data items are no longer required: Ambiguous Terminology, Date of Conclusive Diagnosis, Multiplicity Counter, Date of Multiple Tumors, and Type of Multiple Tumors Reported as One Primary.

Four Clinical Trial data items were added (type, date, site, and text) and these items are repeated to capture up to four different clinical trials per patient.

Also in 2013, these drugs, which were coded as chemotherapy, are now considered immunotherapy:
- Alemtuzumab/Campath
- Bevacizumab/Avastin
- Rituximab
- Trastuzumab/Herceptin
- Pertuzumab Perjeta
- Cetuximab/Erbitux

K. CHANGES FOR 2014

Collaborative Stage Version 02.05 was implemented. Cases diagnosed from January 1, 2014 forward must be entered using CS V02.05. This version contained a few corrections to the mapping algorithm, and several clarifications to the coding instructions with this version, Grade Path System and Grade Path Value were discontinued, as well as all Site Specific Factors that had been defined by never required by any standard setter.

The Tumor Grade field was changed slightly in 2014, with all standard setters (COC, SEER, and NPCR) in agreement with the new coding instructions.

New preferred terms and synonyms were added to the ICD-0-3 histology table.

A revised version of the Hematopoietic and Lymphoid Neoplasm Database was released in 2014.

L. CHANGES FOR 2015

Two new code values were added to the SEX field: 5 - Transsexual, natal male and 6 - Transsexual, natal female.

Pathological stage data elements T, N, M, and stage group are now required to be coded.

Carcinoids of the appendix are now considered reportable (8240/3). Nature teratomas of the testes in adults is malignant and reportable (9080/3). It is not reportable for pre-pubescent males.

New terms for pancreatic cancers are now reportable:

- Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high grade dysplasia is reportable. This term replaces mucinous cystadenocarcinoma, non-invasive (8470/2).

- Cystic pancreatic endocrine neoplasm (CPEN) is reportable. Assign code 8150/3, unless specified as NET grade 1 (8240/3) or NET grade 2 (8249/3).

- Solid pseudopapillary neoplasm of the pancreas is reprotable as 8452/3.

Directly coded Summary Stage 2000, Treatment Follow-back Text, and Treatment Plan were added as new data items.

Determining the Number of Primaries

DETERMINING THE NUMBER OF PRIMARY CASES TO ABSTRACTED

Use the following references to determine the number of cases to be abstracted:

Solid Tumors -- Use the SEER 2007 Multiple Primary and Histology Coding Rules for solid tumors diagnosed on or after January 1, 2007. Use the SEER Multiple Primary rules in effect prior to 2007 for solid tumors diagnosed before 2007.

Hematopoietic Malignancies -- Use the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the Hematopoietic Database for cases of this type diagnosed on or after January 1, 2010. Use Appendix A, 'Rules for Determining Multiple Primaries for Lymphatic and Hematopoietic Diseases,' for cases diagnosed prior to that date.

SEER Multiple Primary and Histology Coding Rules

The SEER 2007 Multiple Primary and Histology Coding Rules are effective with cases diagnosed on or after January 1, 2007. They contain site-specific rules for lung, breast, colon, melanoma of the skin, head and neck, kidney, renal pelvis/ureter/bladder, and malignant and benign brain tumors. An additional set of rules addresses the specific and general rules for all other sites. The multiple primary rules guide and standardize the process of determining the number of primaries to be abstracted. The histology rules contain detailed histology coding instruction. The complete Multiple Primary and Histology Coding rules may be downloaded from the SEER web site at: http://seer.cancer.gov/tools/mphrules/download.html.

The SEER 2007 Multiple Primary and Histology Coding Rules do not apply to hematopoietic primaries (lymphoma and leukemia M9590-9989).

Use the Site-specific rules for the following primary site groups:

Brain, malignant
Brian, benign
Breast
Colon
Head and Neck
Kidney
Lung
Malignant Melanoma of the skin
Renal pelvis, ureter, bladder, and other urinary

Use the Other Sites Rules for solid malignant tumors that occur in primary sites not covered by site-specific rules.

2010 Hematopoietic and Lymphoid Malignancy Coding Rules

New reportability instructions and data collection rules for hematopoietic and lymphoid neoplasms go into effect for cases diagnosed beginning January 1, 2010. The Hematopoietic Database is an electronic tool developed to assist in screening for reportable cases and determining reportability requirements, as well as determination of multiple primaries. The database contains abstracting and coding information for all hematopoietic and lymphoid neoplasms (9590/3-9992/3).

Two tools have been developed for use beginning in 2010:

- The *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual*
- The Hematopoietic Database

The *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* is embedded in the Hematopoietic Database (Hematopoietic DB). This manual contains reportability instructions and rules for determining the number of primaries, the primary site and histology, and the cell lineage or phenotype. The manual also includes several appendices. Use the instructions and rules within the manual first. The Hematopoietic DB is used when the rules specifically instruct the abstractor to refer to the DB or when the registrar has used all of the rules in the manual. The Hematopoietic and Lymphoid Database was updated in 2014, but all coding changes are effective with 2010 cases forward.

The manual and database are available online and for download from the SEER web site: http://seer.cancer.gov/tools/heme/index.html.

Pre-2007 Multiple Primary Coding Rules

For solid malignant tumors and benign/borderline brain tumors diagnosed before 2007, use the SEER Multiple Primary Rules below, which are based on the *International Classification of Diseases for Oncology* (ICD-O-3), to determine if a diagnosis is a single or multiple primary.

1. Use the definitions below under the heading "Primary Site" to decide whether the tumor(s) involve one site or multiple sites.

2. Follow the instructions under the heading "Rules for Coding Histology of Solid Tumors Diagnosed Prior to 2007" in item #30090 (Histology) to decide whether the tumor(s) are a single histology or mixed/multiple histologies.

3. Use the"Rules for Determining Multiple Primary Cancers" to decide whether the case should be abstracted as one primary or multiple primaries.

1. Definitions for determining a single site and a single histology.

Primary Site

A single site is defined as the same first three characters in the topography code for the sites listed below:

Code	Description
C03	Gum
C04	Floor of mouth
C11	Nasopharynx
C14	Oral, other and ill-defined
C15	Esophagus
C16	Stomach
C17	Small intestine
C19	Rectosigmoid junction
C20	Rectum
C22	Liver and bile ducts
C25	Pancreas
C26	Digestive, other and ill-defined
C32	Larynx
C39	Respiratory, other and ill-defined
C42	Hematopoietic and reticuloendothelial
C44	Skin, other than melanoma
C48	Retroperitoneum and peritoneum

C50	Breast
C53	Cervix uteri
C54	Corpus uteri
C55	Uterus NOS
C58	Placenta
C61	Prostate
C62	Testis
C67	Bladder
C69	Eye and adnexa
C70	Meninges
C71	Brain
C72	CNS
C73	Thyroid
C76	Ill-defined sites
C77	Lymph nodes
C80	Unknown primary

EXAMPLE: The trigone of bladder (C67.0) and lateral wall of bladder (C67.2) are considered subsites of the bladder, and would be treated as one site. A tumor or lesion involving both subsites would be coded either to overlapping sites of bladder (C67.8), or bladder, NOS (C67.9).

A single site is defined as the same fourth character in the topography code for the anatomic sites listed below:

Code	Description
C18	Colon
C21	Anus
C38.4	Pleura
C40	Bones of limbs
C41	Bones of other sites
C44	Melanoma of skin
C47	Peripheral and autonomic nervous system
C49	Connective tissue

EXAMPLE: The transverse colon (C18.4), and the descending colon (C18.6), are considered separate sites. The only EXCEPTION to this is familial polyposis or polyposis coli involving more than one segment of the colon. This is abstracted as only one primary, coded to colon, NOS (C18.9). If the familial polyposis involves both the colon and the rectum, abstract as one primary with site code C19.9.

A single site involves more than one three character category in the topography coding scheme for the anatomic sites listed below:

Code	Description	Code To:
C01 and C02	Tongue	C02.9
C05 and C06	Palate and other unspecified parts of mouth	C06.9
C07 and C08	Parotid and other major salivary glands	C08.9
C09 and C10	Tonsil and oropharynx	C10.9
C12 and C13	Pyriform sinus and hypopharynx	C13.9
C23 and C24	Gallbladder and other parts of biliary tract	C24.9
C30 and C31	Nasal cavity, middle ear, and accessory sinuses	C31.9
C33 and C34	Trachea and bronchus and lung	C34.9
C37 and C38 (except 38.4)	Thymus, heart, mediastinum, and overlapping lesions	C38.3
C51, C52, and C57.7-C57.9	Vulva, vagina, and other and unspecified parts of female genital organs	C57.9
C56 and C57.0-C57.4	Ovary, fallopian tube, broad ligament, round ligament, parametrium, and uterine adnexa	C56.9 if ovary; C57.9 if other
C60 and C63	Penis and other and unspecified male genital organs	C63.9
C64, C65, C66, and C68	Kidney, renal pelvis, ureter, and other and unspecified urinary organs	C64.9 if kidney; C68.9 if other
C74 and C75	Adrenal gland and other endocrine glands and related structures	C75.9

EXAMPLE: Base of tongue (C01.9), and border of tongue (C02.1), are considered subsites of the tongue, and would be treated as one site - either overlapping lesion of tongue (C02.8) or tongue, NOS (C02.9).

Each side of a paired organ is considered a separate site. Tumors arising on different sides of a paired organ are considered separate primaries, unless the tumor on one side is stated to be metastatic. Exceptions are bilateral involvement of the ovaries in which a single histology is reported, bilateral retinoblastomas, and bilateral Wilms' tumors, which are all considered single primaries.

Histologic Type

When the **FIRST THREE DIGITS** of the ICD-O-3 morphology codes are **IDENTICAL**, the lesions are the **SAME HISTOLOGY,** except for lymphatic and hematopoietic diseases and benign and borderline CNS tumors.

Exception: Code the following as single primaries with a single histology, even though the first three digits of the ICD-O-3 morphology codes differ:

Bladder lesions (8120-8130)
Breast lesions (ductal carcinoma - 8500/3) and (lobular carcinoma - 8520/3) Code to 8522/3

Exception: Non-small cell carcinoma (8046/3) is **not** considered the same as 8041/3-8045/3, even though the first three digits are the same.

Exception: Lymphatic and hematopoietic diseases (see "Pre-2010 Lymphatic and Hematopoietic Multiple Primary Rules" and use Appendix A to determine multiple primaries).

Exception: Benign and borderline CNS tumors (see the section "Rules for Determining Multiple Primaries for Benign and Borderline Intracranial and CNS Tumors" below for multiple primary rules).

Simultaneous/synchronous diagnosis

Diagnoses that occur within two months of each other are considered simultaneous.

2. Rules for Determining Multiple Primary Cancers (**except for lymphatic and hematopoietic diseases and benign and borderline CNS tumors**).

Single Primary

1. A single lesion of one histologic type is considered a single primary even if the lesion crosses site boundaries.

2. A single lesion with multiple histologic types is to be considered as a single primary. The most frequent combinations are listed in ICD-O-3. For example, combination terms such as "adenosquamous carcinoma (8560/3)" or "combined

small cell-large cell carcinoma (8045/3)" are included. Any of these mixed histologies are to be considered one primary.

3. A single lesion with an in-situ component and an invasive component is considered a single primary.

4. a) If a new cancer of the same histology as an earlier one is diagnosed in the same site within two months, consider this to be the same primary cancer.
b) If a new cancer of the same histology is diagnosed in the same site after two months, consider this new cancer a separate primary unless stated to be recurrent or metastatic.

Exception to 4b: If there is an in-situ cancer followed by an invasive cancer in the same site with the same histology more than two months apart, report as two primaries even if stated to be a recurrence.

NOTE: Bladder cancers, site codes C67.0 - C67.9, with histology codes 8120-8130 may be abstracted at most twice; one abstract for the first in-situ lesion if it precedes the first invasive lesion, and one for the first invasive lesion (if diagnosed at least 2 months later than the in-situ lesion). This also applies to adenocarcinoma of the prostate. These are reported at most only twice; once for the first in-situ lesion if it precedes the first invasive lesion (these are very rare) and once for the first invasive lesion.

NOTE: Kaposi's sarcoma (9140/3) is reported only once. Kaposi's sarcoma is coded to the site in which it arises. If Kaposi's sarcoma arises in skin and another site simultaneously, code to skin (C44._). If no primary site is stated, code to skin (C44._).

5. Multiple lesions of the same histologic type:

   a. Simultaneous multiple lesions of the same histologic type within the same site will be considered a single primary. Further, if one lesion has a behavior code of in-situ and another has a behavior code of malignant (invasive), still consider this to be a single primary whose behavior is malignant.

   b. Multiple lesions of the same histologic type occurring in different sites are considered to be separate primaries unless stated to be metastatic.

   Exception: Adenocarcinoma in multiple adenomatous polyps of the colon.

NOTE: For paired organs, each side is considered a separate site.

c. If only one histologic type is reported and if both sides of a paired site are involved within two months of diagnosis, a determination must be made as to whether the patient has one or two independent primaries. If it is determined that there are two independent primaries, two records are to be submitted, each with the appropriate laterality and extent of disease information.
There are THREE EXCEPTIONS to this rule. Simultaneous bilateral involvement of the ovaries in which there is only a single histology is to be considered one primary and laterality is to be coded '4'. Bilateral retinoblastomas and bilateral Wilms' tumor are always considered single primaries (whether simultaneous or not), and laterality is coded as '4'.

d. If one histologic type is reported in one side of a paired organ and a different histologic type is reported in the other paired organ, consider these two primaries unless there is a statement to the contrary.

EXAMPLE: If a ductal lesion occurs in one breast and a lobular lesion occurs in the opposite breast, these are considered to be two primaries.

6. Multiple lesions of different histologic types:

a. Multiple lesions of mixed histologies in the same site are a single primary.

EXAMPLE: Tumors with predominant features or combination codes such as combined small cell-large cell carcinoma 8045/3.

b. Multiple lesions of different histologic types within a single site are to be considered separate primaries whether occurring simultaneously or at different times.

Exception: For multiple lesions within a single site occurring within two months, if one lesion is stated to be carcinoma, NOS, adenocarcinoma, NOS, Melanoma, NOS, or sarcoma, NOS and the second lesion is a more specific term, such as large cell carcinoma, mucinous adenocarcinoma, or spindle cell sarcoma, consider this to be a single primary and code to the more specific term.

Exception: Within each breast, combinations of ductal and lobular carcinoma occurring within two months of each other are to be considered a single primary and the histology coded according to ICD-O-3. (8522/3)

Exception: Thyroid carcinomas, reported with two separate carcinomas - one papillary and the other follicular - should be reported as one primary with the mixed histology code 8340/3.

c. Multiple lesions of different histologic types occurring in different sites are considered separate primaries whether occurring simultaneously or at different times.

LESIONS	SITE(S)	HISTOLOGY	VARIABLES	PRIMARY
Single	Single	Single		Single
	Single	Mixed/multiple		Single
Single or multiple*	Single	Single	Different behavior codes, in-situ (2) and invasive (3)	Single
	Same as previous site	Same as previous histology	Within two months of diagnosis	Recurrence of the original primary
	Same as previous site	Same as previous histology	More than two months after diagnosis	New primary unless physician states it is metastatic. **Exceptions:** bladder, Kaposi's sarcoma, adenocarcinoma of prostate.
	Same as previous site	Invasive after in-situ	More than two months after diagnosis	New primary even if stated as recurrence.
Multiple*	Single	Single	Simultaneous	Single
	Multiple	Single	Simultaneous	Multiple UNLESS physician states metastatic.
	Paired site	Single	Simultaneous	Physician determines **Exceptions:** Ovaries (simultaneous bilateral), retinoblastoma, and Wilms' tumor are single primaries.
	Paired site	Multiple	Simultaneous	Multiple
	Single	Mixed	Simultaneous	Single

	Single	Multiple (Each tumor has a different histology.)	Simultaneous or different	Multiple **Exceptions:** Breast (lobular and ductal); bladder (transitional and papillary,) and thyroid (papillary and follicular).
	Multiple	Multiple	Simultaneous or different	Multiple

*See the preceding site and histology rules for definition of "multiple".

Rules for determining multiple primaries for benign and borderline intracranial and CNS tumors (C70.0 - C72.9, C75.1 - C75.3):

For non-malignant CNS tumors, subsite, histology, and laterality must be considered.

A.. Primary Site -

A single site is defined as the same fourth character (subsite) in the topography code for the anatomic sites listed below:

C70	Meninges	C72 Spinal Cord and Cranial Nerves
C71	Brain	C75 Pituitary, Pineal, Craniopharyngeal

If different tumors arise in different subsites, then they are separate primaries.

Example: A benign tumor in the parietal lobe (C71.3) and a separate benign tumor in the frontal lobe (C71.1). Count and abstract as separate primaries.

Example: Meningioma of cervical spine dura (C70.1) and separate meningioma overlying occipital lobe (C70.0, cerebral meninges). Count and abstract as separate primaries.

Exception: If one subsite is non-specific (such as brain, NOS C71.9), and other is specific in same 3 character category (such as C71.__), count as one primary only. For example, biopsy of temporal lobe (C71.2) shows benign tumor and diagnosis from CT scan states "neoplasm of brain" (C71.9). Report one primary only (C71.2).

B. Histology -

If separate tumors have different histologies, then they are separate primaries. To determine whether tumors have different histologies, code the histology of each tumor and look them up in the table below.

Histologic Groupings To Determine Same Histology for Non-malignant Brain Tumors

Choroid plexus neoplasms	9390/0, 9390/1
Ependymomas	9393, 9394, 9444
Neuronal and neuronal-glial neoplasms	9384, 9412, 9413, 9505/1, 9506, 9442

Neurofibromas	9540/0, 9540/1, 9541, 9550, 9560/0
Neurinomatosis	9560/1
Neurothekeoma	9562
Neuroma	9570
Perineurioma, NOS	9571/0

1. If neither histology code is in the table above and codes are the same at the three-digit level, abstract as one primary.

   Example: Patient has clear cell meningioma (9538/1) of the cerebral meninges and a separate transitional cell meningioma (9537/0) in another part of the same hemisphere. Count and abstract as one primary.

2. If the two histology codes are in the same category of the table, count as one primary.

   Example: Patient has a ganglioglioma (9505/1) of the cerebellum (C71.6) and a neurocytoma (9506/1) of the cerebellopontine angle (C71.6). Count and abstract as one primary.

3. If the histology codes are in different categories of the table, count and abstract as separate primaries.

   Example: Patient has a choroid plexus papilloma (9390/0) of the third ventricle (C71.5) and a choroid glioma (9444/1) of the third ventricle (C71.5). Count and abstract as separate primaries.

4. If one histology is in the benign brain histology table and the other is not, compare codes at the three-digit level. If they are the same, count as one primary. If they are different, count as two primaries.

   Example: Patient has a subependymal glioma (9383/1) diagnosed on needle biopsy in August, and at resection in September the diagnosis is subependymal giant cell astrocytoma (9384/1). Count and abstract as one primary.

   Example: Patient has a Pacinian tumor (9507/0) diagnosed in March and a dysembryoplastic neuroepithelial tumor (9413/1) of the occipital lobe diagnosed in July. Count and abstract as separate primaries.

C. Laterality -

For each non-malignant (and malignant) primary brain and CNS tumor for the sites shown below and with a diagnostic date on or after January 1, 2004, code laterality using codes 1-4 or 9. Midline tumors are coded 9.

Prior to 1-1-04 diagnoses, primary brain and CNS tumors were coded '0' for laterality.

CNS Sites for which laterality is to be coded:

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

1. If laterality is same side, one side unknown or not applicable, and same subsite and same histology, then abstract as one primary.

2. If laterality is both sides, abstract separate primaries.

   Example: Benign tumors (same histology) in left and right temporal lobes. Count and abstract as separate primaries.

D. Timing -

If a new non-malignant tumor is diagnosed in the same subsite with the same histology as a previous one, then one primary is abstracted, regardless of time elapsed. (For tumors with an initial diagnosis prior to 1-1-04, do not abstract recurrent non-malignant CNS tumors.)

E. Multiple lesions with different behavior codes -

1. Non-malignant tumor followed by malignant tumor: abstract separate primaries regardless of timing.

2. Malignant tumor followed by non-malignant tumor: abstract separate primaries regardless of timing.

3 . Benign tumor transforms to malignancy (rare occurrence): create second abstract for malignancy.

   Example: Patient is diagnosed and treated for choroid plexus papilloma (9390/0) of right lateral ventricle in June 2004. Eighteen months later, patient is symptomatic again and re-biopsy of same area is reported as choroid plexus carcinoma (9390/3). Count and abstract as two primaries.

Pre-2010 Rules for Determining Multiple Primaries for Hematopoietic and Lymphoid Diseases (9590-9989):

If the physician clearly states that a hematopoietic diagnosis is a new primary, use that information. Otherwise, the determination of multiple primaries should be done using the guidelines in Appendix A.

Rules: 1. Topography is NOT considered in determining multiple primaries of lymphatic and hematopoietic diseases.

2. The time interval between diagnoses does NOT enter into the decision.

Appendix A was completely revised with the implementation of ICD-O-3 and the newer table for determining multiple hematopoietic malignancies is effective with cancers diagnosed between 2001-2010. Appendix A contains links to both the revised table and the previous table, which is to be used for pre-2001 diagnoses.

One of the major changes that took place with the implementation of ICD-O-3 was the inclusion of newly reportable hematopoietic diseases (myeloproliferative and myelodysplastic syndromes). These cases are <u>not</u> accessioned or sequenced <u>unless they were diagnosed on or after January 1, 2001</u>, even if the patient received treatment for this disease after that date.

NOTE: If a reportable hematopoietic malignancy is diagnosed after January 1, 2001 in the same person who has another hematopoietic disease diagnosed prior to 2001, use Appendix A to determine if the second condition must be abstracted. If the cross check is D, it should be abstracted. If the cross check is S, it should not be abstracted if the first condition was abstracted; it should be abstracted if the first condition was not.

Patient Data

10020 - SOCIAL SECURITY NUMBER

Field Length: 9

Enter the patient's social security number in the field provided. If the patient does not have a social security number, use the formula below to assign a unique temporary number.

NOTE: The social security number is the main element used in identifying patients, matching information, etc., and must be recorded accurately for every patient entered in the system.

FORMULA: Temporary "social security" numbers are assigned only to patients not possessing a verifiable social security number. Use the initials of the patient's first, middle and last names, followed by digits representing the birth date. (Use zero when the patient's middle initial is unknown.)

Thus, John Brown, born January 21, 1946, would be issued the following number:

J0B - 01 - 2146

Where month, day or year of birth is not known, enter "99".

Temporary numbers should be checked for duplication within your hospital's cancer registry before the patient is accessioned. If the temporary number works out to be exactly the same as that of a different patient, the registrar should change the middle initial to the number "1". If there are more than two patients with the same temporary number, continue to substitute numbers in the middle initial in sequential order.

[FYI: If the Medicare billing number is a Social Security Number followed by a B or D, this indicates that the SSN belongs to the spouse of the patient.]

10030 - LAST NAME

Field Length: 20

Enter the patient's last name in the spaces provided. If the name exceeds the number of spaces provided, enter as much as possible. If during the course of follow-up, the patient's name changes, update the record with the current name.

Use the following rules when recording patient last names:

1. Name fields should contain alpha characters and blanks only -- no special characters such as apostrophes, commas, hyphens, etc.

2. Any name titles or suffixes, such as DR., M.D., MR., MS., JR., SR., III, IV, and so on, should be recorded in the middle name field after, or instead of, the middle name. These data are optional, and need not be recorded at all.

3. Blanks are allowed in the last name field, but they must be used consistently in order to match patients at the central data base. Therefore, the following rules are established:

    a. When a patient has two last names, or a hyphenated last name, you may type both in the last name field separated by a blank space.

    b. Patients with two-part last names, such as VAN HORN or ST JOHN, may have a space between the two parts, but no special punctuation marks.

    c. Names like 'MCCOY' or 'O'BRYAN' should be typed 'MCCOY' or 'OBRYAN' with no spaces and no punctuation.

10040 - FIRST NAME

Field Length: 15

Enter the patient's first name in the spaces provided. If the name exceeds the number of spaces provided, enter as much as possible.

Use the following rules when recording the patient's first name:

1. Name fields should contain alpha characters and blanks only -- no special characters such as apostrophes, commas, hyphens, etc.

2. Any name titles or suffixes, such as DR., M.D., MR., MS., JR., SR., III, IV, and so on, should be recorded in the middle name field after, or instead of, the middle name. These data are optional, and need not be recorded at all.

3. Blanks are allowed in the first name field, but they must be used consistently in order to match patients at the central data base. Therefore, the following rules are established:

    a. Patients with two-part first names, or two first names, may have them both recorded in the first name field, separated by a blank space. For example: MARY JO MARY ANN JOHN ED etc.

    b. Patients who go by their initials should have their first initial recorded in the first name field, and the second in the middle name field. For example: J.B. JONES would have 'J' in first name and 'B' in middle name.

    c. Patients with a name and an initial should have them recorded in separate fields. For example: H. EDWARD SMITH should have 'H' in first name and 'EDWARD' in middle name.

10050 - MIDDLE NAME

Field Length: 10

Enter the patient's middle name in the spaces provided. If the name exceeds the number of spaces, enter as much as possible. If only an initial is given, enter the initial.

You may also record the patient's title or name suffix in this field -- such as: DR, JR, SR, III, M.D., etc.

10055 - MAIDEN NAME

Field Length: 15

This is a required field if the patient's maiden name is available. Leave blank for males or if it is unknown.

10060 - CURRENT STREET ADDRESS - LINE 1

Field Length: 40

Record the currently known number and street address of the patient's usual residence. Leave a blank between numbers and words if space permits. Punctuation should be limited to slashes for fractional addresses (i.e., 103 1/2 MAIN ST) and hyphens (289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 408. **Do not use periods after abbreviations.** When entering addresses, use the U.S. Postal Service Guidelines found at: http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf

This item is different from patient address at diagnosis in that it provides a current address for follow-up purposes. Address-Line 1 will be used for mailing labels, so it should contain the patient's mailing address. This item should be updated as newer information becomes available.

Normally a residence is the home named by the patient. Do not use a temporary address. Legal status and citizenship are not factors in residency decisions. Rules of residency are identical to or comparable with rules used by the Census Bureau whenever possible.

Rules for persons without apparent residences:

Persons with More than One Residence (summer and winter homes): Use the address the patient specifies if a usual residence is not apparent.

Persons with No Usual Residence (transients, homeless, migrant workers): Use the address of the place they were staying when the cancer was diagnosed. This could be a shelter or the diagnosing institution.

Persons Away at School: College students are residents of the school area. Boarding school children below college level are residents of their parents' home.

Persons in Institutions: The Census Bureau states "Persons under formally authorized, supervised care or custody" are residents of the institution. This includes:

-Incarcerated persons
-Persons in homes, schools, hospitals, or wards for the physically disabled, mentally retarded, or mentally ill
-Long-term residents of other hospitals, such as Veterans Administration (VA) hospitals

Persons in the Armed Forces and on Maritime Ships: Members of the armed forces are residents of the installation area. Use the stated address for military personnel and their family. Military personnel may use the installation address or the surrounding community's address.

10070 - CURRENT STREET ADDRESS - LINE 2

Field Length: 40

This field provides space to record additional address information, such as the name of a nursing home, apartment complex, etc. This line will not be displayed on mailing labels. If the patient has both a PO Box (for a mailing address), and a street name and number (for a living address), put the street name and number on address-line 2. Update this item if the patient's address changes. Leave this field blank if the additional address space is not needed.

10080 - CURRENT ADDRESS - CITY

Field Length: 20

Enter the city of current residence in the spaces provided. Abbreviate only if necessary. A list of Kentucky cities and towns is located in Appendix D. This item is different from city at diagnosis in that it provides the current city or town for follow up purposes. This item should be updated as newer information becomes available.

Additional rules for determining residency may be found under the data item "CURRENT STREET ADDRESS."

10090 - CURRENT ADDRESS - STATE

Field Length: 2

Record the two character abbreviation for the state in which the patient currently resides. Refer to Appendix B also for a list of the state abbreviations. Appendix B contains abbreviations for U.S. territories and Canadian provinces, as well. Residents of the United States, or its territories, with the state unknown should be coded to ‘US’. Residents of Canada and the province unknown should be coded to ‘CD’. Residents of countries outside the United States, its territories, or Canada, should be coded with the two-character code 'XX' or 'YY' if the state or country or current residence is unknown. Residence unknown should be coded ‘ZZ’.

This item is different from state at diagnosis in that it provides the current state or country for follow up purposes. This item should be updated as newer information becomes available. Update this data item if patient’s state of residence changes. Do not change this item when the patient dies.

Additional rules for determining residency may be found under the data item "CURRENT STREET ADDRESS."

Examples:

Code	Description
KY	If the state in which the patient resides at the time of diagnosis and treatment is Kentucky, then use the USPS code for the state of Kentucky
XX	Resident of a country of than the U.S. (including it territories, commonwealths, or possessions) or Canada and the country is *known*
YY	Resident of a country other than the U.S. (including it territories, commonwealths, or possessions) or Canada and the country is *unknown*
US	Resident of the U.S. (including it territories, commonwealths, or possessions) and the state is *unknown*
CD	Resident of Canada and the province is *unknown*
ZZ	Residence unknown

10100-10110 - CURRENT ADDRESS - ZIP CODE

Field Length: 9

Enter the nine digit zip code for the patient's current address. If only five digits are given, record those and leave the rest of the field blank.

Refer to the U.S. Postal Service web site (see Appendix D) for the appropriate code if none is recorded in patient's record.

Code 888888888 if the patient's address is in a county other than Canada, the United States, or U.S. possessions. Code 999999999 if the patient's address is in Canada, the United States, or a U.S. possession, but the zip code is unknown.

This item is different from zip code at diagnosis in that it provides the current zip code for follow up purposes. This item should be updated as newer information becomes available.

Additional rules for determining residency may be found under the data item "CURRENT STREET ADDRESS."

10111 - CURRENT ADDRESS - COUNTRY

Field Length: 3

Record the three character abbreviation for the country in which the patient currently resides. This item corresponds to Current Address – State. See APPENDIX B.

Common Country Codes

Code	Description
USA	United States
CAN	Canada
ZZX	Not US or Canada, but no other information
ZZU	Unknown

10120 - HOME TELEPHONE NUMBER

Field Length: 10

Enter the patient's area code in the first three spaces followed by the seven digit number.

Enter '0000000000' if the patient does not have a telephone.

Enter '9999999999' if the telephone number is unknown.

10130 - DATE OF BIRTH

Field Length: 8

Enter the month, day, and year the patient was born. Precede all single digit dates with "0".

If the exact day is unknown, code the 15th of the month.

If the month is unknown, approximate or code as June. If the year is unknown, enter your best estimate. You must use a valid date. Do not leave
blank.

10141 - STATE OF BIRTH

Field Length: 2

Record the 2 character abbreviation for the patient's state of birth. See APPENDIX B for alphabetic listings of the appropriate codes and their definitions. Use the most specific code.

Code 'ZZ' when unknown.

Examples:

Code	Description
KY	If the state in which the patient was born is Kentucky, then use the USPS code for the state of Kentucky.
XX	State of birth other than the U.S. (including it territories, commonwealths, or possessions) or Canada and the country is *known*.
YY	State of birth other than the U.S. (including it territories, commonwealths, or possessions) or Canada and the country is *unknown*.
US	Born in the U.S. (including it territories, commonwealths, or possessions) and the state is *unknown*.
CD	Born in Canada and the province is *unknown*.
ZZ	State of birth and country are unknown.

10142 - COUNTRY OF BIRTH

Field Length: 3

Record the 3 character abbreviation for the patient’s country of birth. See APPENDIX B.

Common Country Codes

Code	Description
USA	United States
CAN	Canada
ZZN	North America, NOS
ZZC	Central America, NOS
ZZS	South America, NOS
ZZP	Pacific, NOS
ZZE	Europe, NOS
ZZF	Africa, NOS
ZZA	Asia, NOS
ZZX	Not US or Canada, but no other information
ZZU	Unknown

10150 - SEX

Field Length: 1

Enter the one character code which describes the patient's sex:

Code	Description
1	Male
2	Female
3	Other (hermaphrodite)
4	Transsexual, NOS
5	Transsexual, natal male
6	Transsexual, natal female
9	Unknown

If the patient is transsexual, code to the gender at birth, if known.

10160 - RACE1

Field Length: 2

Enter the two digit code which describes the patient's race group. If the patient is multiracial, code all races using data fields Race2-Race5. **Effective with 2004 diagnoses, use the race coding rules and tables in** APPENDIX K.

Code	Description
01	White
02	Black
03	American Indian, Aleutian, Eskimo
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai
15	Asian Indian or Pakistani, NOS (formerly 09)
16	Asian Indian
17	Pakistani
21	Chamorran
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
96	Other Asian including Asian, NOS and Oriental, NOS
98	Other
99	Unknown

-White includes Mexican, Puerto Rican, Cuban, and all other Caucasians.

-Black includes the designations Negro or Afro-American.

-Race is based on birth place information when place of birth is given as China, Japan, or the Philippines, and race is reported only as Asian, Oriental, or Mongolian.

10170 - RACE2

Field Length: 2

Enter the two digit code which describes the patient's race group. **If the patient is multiracial, code all races using data fields Race2-Race5.**

Code	Description
01	White
02	Black
03	American Indian, Aleutian, Eskimo
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai
15	Asian Indian or Pakistani, NOS (formerly 09)
16	Asian Indian
17	Pakistani
21	Chamorran
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
96	Other Asian including Asian, NOS and Oriental, NOS
98	Other
99	Unknown

-White includes Mexican, Puerto Rican, Cuban, and all other Caucasians.

-Race is based on birth place information when place of birth is given as China, Japan, or the Philippines, and race is reported only as Asian, Oriental, or Mongolian.

-**If Race1 is '99', then Race2 through Race5 must be '99'**

10180 - RACE3

Field Length: 2

Enter the two digit code which describes the patient's race group. **If the patient is multiracial, code all races using data fields Race2-Race5.**

Code	Description
01	White
02	Black
03	American Indian, Aleutian, Eskimo
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai
15	Asian Indian or Pakistani, NOS (formerly 09)
16	Asian Indian
17	Pakistani
21	Chamorran
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
96	Other Asian including Asian, NOS and Oriental, NOS
98	Other
99	Unknown

-White includes Mexican, Puerto Rican, Cuban, and all other Caucasians.

-Race is based on birth place information when place of birth is given as China, Japan, or the Philippines, and race is reported only as Asian, Oriental, or Mongolian.

- **If Race1 is '99', then Race2 through Race5 must be '99'**

10190 - RACE4

Field Length: 2

Enter the two digit code which describes the patient's race group. **If the patient is multiracial, code all races using data fields Race2-Race5.**

Code	Description
01	White
02	Black
03	American Indian, Aleutian, Eskimo
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai
15	Asian Indian or Pakistani, NOS (formerly 09)
16	Asian Indian
17	Pakistani
21	Chamorran
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
96	Other Asian including Asian, NOS and Oriental, NOS
98	Other
99	Unknown

-White includes Mexican, Puerto Rican, Cuban, and all other Caucasians.

-Race is based on birth place information when place of birth is given as China, Japan, or the Philippines, and race is reported only as Asian, Oriental, or Mongolian.

- **If Race1 is '99', then Race2 through Race5 must be '99'**

10200 - RACE5

Field Length: 2

Enter the two digit code which describes the patient's race group. **If the patient is multiracial, code all races using data fields Race2-Race5.**

Code	Description
01	White
02	Black
03	American Indian, Aleutian, Eskimo
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai
15	Asian Indian or Pakistani, NOS (formerly 09)
16	Asian Indian
17	Pakistani
21	Chamorran
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
96	Other Asian including Asian, NOS and Oriental, NOS
98	Other
99	Unknown

-White includes Mexican, Puerto Rican, Cuban, and all other Caucasians.

-Race is based on birth place information when place of birth is given as China, Japan, or the Philippines, and race is reported only as Asian, Oriental, or Mongolian.

- **If Race1 is '99', then Race2 through Race5 must be '99'**

10210-10220 - Computer-Derived Name-Based Ethnicity

This field contains codes identifying ethnicity as determined by a software algorithm or computer list-based method to identify cancer patients' ethnicity based on last name or maiden name. The effective date for implementation of this field is for cases diagnosed January 1, 1995, and after.

There are two parts to this field:
Computed Ethnicity
Computed Ethnicity Source

10210 - Computed Ethnicity:
Field Length: 1

Code	Description
0	No match was run for 1995 and later cases
1	Non-Hispanic last name and non-Hispanic maiden name
2	Non-Hispanic last name, didn't check maiden name (or male)
3	Non-Hispanic last name, missing maiden name
4	Hispanic last name, non-Hispanic maiden name
5	Hispanic last name, didn't check maiden name (or male)
6	Hispanic last name, missing maiden name
7	Hispanic maiden name (females only) (regardless of last name)
Blank	1994 and earlier cases

10220 - Computed Ethnicity Source:
Field Length: 1

Code	Description
0	No match was run for 1995 and later cases
1	Census Bureau list of Spanish surnames, NOS
2	1980 Census Bureau list of Spanish surnames

3	1990 Census Bureau list of Spanish surnames
4	GUESS program
5	Combination list including South Florida names
6	Combination of Census and other locally generated list
7	Combination of Census and GUESS, with or without other lists
8	Other type of match
9	Unknown type of match
Blank	1994 and earlier cases

10230 - SPANISH ORIGIN

Field Length: 1

Code the patient's Spanish/Hispanic ethnicity.
The codes are:

Code	Description
0	Non-Spanish
1	Mexican
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other Spanish (includes European)
6	Spanish, NOS (There is evidence other than the patient's surname that the patient is Hispanic, but he/she cannot be assigned to codes 1-5 above.)
7	Spanish surname only
8	Dominican Republic (effective with 1/1/2005 cases)
9	Unknown whether Spanish or not

Persons of Spanish surname or origin may be of any race.

Portuguese and Brazilians are not considered Spanish and should be coded 0.

See APPENDIX L for a list of commonly occurring Hispanic surnames.

10240 - Tobacco use

Field Length: 1

Enter the code which describes the patient's tobacco use. Record as a cigarette smoker if the chart says only "smoker" or "tobacco user".

Code	Description
0	Never used
1	Cigarette smoker
2	Cigar/pipe smoker
3	Snuff/chew/smokeless tobacco user
4	Mixed use of more than one type of tobacco product
9	Not recorded/unknown

10250 - Cigarette Pack Years

Field Length: 3

Enter the total pack years for the span of cigarette use. Pack years equal the average number of packs smoked per day multiplied by the number of years of cigarette use. For example, if a person smokes two packs a day for 30 years, then the cigarette pack years equals 60.

- Enter "0" if patient never smoked cigarettes.
- Enter "999" if the pack years of cigarette use is unknown.

The computer will automatically right justify digits at data entry.

10260 - Number of Live Births

Field Length: 2

For female patients, record the number of live births the patient has delivered. If male, enter "99". The computer will automatically right justify single digit entries.

This is not the same as gravidity or parity. Gravidity refers to the number of pregnancies. Parity refers to the number deliveries of viable offspring (even if stillborn). Number of live births refers to the actual number of offspring born alive.

If unknown, enter "99".

10270 - OCCUPATION

Field Length: 20

Enter the patient's primary occupation throughout his/her lifetime. If retired, enter the primary occupation prior to retirement. This field is required only to the extent that the information is available from source documents. If the patient's occupation is unknown or not recorded, enter 'UNKNOWN' or 'NOT RECORDED'.

10280 - INDUSTRY

Field Length: 20

Enter the industry which describes the type of business activity in which the patient was employed. The U.S. Department of Commerce lists 14 major categories or industry groups, which are listed below for your information.

They are:

Agriculture, Forestry, Fisheries
Mining
Construction
Manufacturing
Transportation, Communications, Public Utilities
Wholesale Trade
Retail Trade
Finance, Insurance, Real Estate
Business and Repair Services
Personal Services
Entertainment and Recreation Services
Professional Services (medical, legal, educational, etc.)
Public Administration
Active Military Duty

This field is required only to the extent that the information is available from the source documents. If the industry is unknown or not applicable, enter 'UNKNOWN' or 'NOT APPLICABLE'.

10290 - UNDERLYING CAUSE OF DEATH (ICD-10)

Field Length: 6

As specified in the SEER Program Coding and Staging Manual, page 207, enter the underlying cause of death ***as coded on the Death Certificate***. Even when the code is believed to be in error, the entry as coded on the Death Certificate is to be used.

Code:	Underlying Cause of Death
0000	Patient alive at last contact
7777	State death certificate or listing not available
7797	State death certificate or listing available, but underlying death not coded.

All other cases: ICD-9 Underlying Cause of Death Code if date of death prior to January 1, 1999 or ICD-10 Underlying Cause of Death Code if date of death on or after January 1, 1999. **Do not code this field from the medical record.** A list of all ICD-10 codes is available online at http://www.who.int/classifications/apps/icd/icd10online/.

Underlying cause of death codes usually have four digits. Some codes may have an optional fifth digit. The decimal point will already appear on the form and on the data entry screen.

If a fourth digit for the underlying cause of death is "X", "blank", or "-" use '9' for the fourth digit.

In Kentucky, the state central registry will match all death certificates with the central database. A file of matched patient records will be generated for each Kentucky hospital. This file will automatically be loaded into CPDMS.net and will be used by each hospital to update that hospital's patients with date of death and cause of death from the death certificate.

It is not necessary to have a copy of the death certificate as long as the official code for the underlying cause of death is available. You may use the Cause of Death code obtained from a linkage with the National Death Index, or from an out-of-state data exchange cancer report.

If the death certificate is not available, do not attempt to code it; use code '777.7'.

For example:

Underlying Cause of Death	ICD-10 Code	Enter:
Cancer of the thyroid	C73	C739
Acute appendicitis with peritonitis	K35.0	K350
Adenocarcinoma of stomach	C16.9	C169

10301 - Contact Patient

Field Length: 1

This field allows the registry to identify patients who should not be directly contacted. The codes are:

Code	Description
0	No
1	Yes

Code 1 is the default value. The value in this field is displayed on the patient status screen when a record has been pulled up in CPDMS.net. When this field is coded '0', the patient will be excluded from Patient Label reports or Follow-Up mailing labels. In the Follow-Up Control List, an "X" will appear adjacent to the patient name in the "Contact Patient" column.

There is an edit check between this field and the fields Next Follow-Up Method (item 31910) and Alternate Follow-Up Method (item 31920). When Contact Patient is coded '0', those two follow-up fields cannot be coded '04' ("Patient by letter") or '05' ("Patient by phone call").

10302 - Contact Patient Comments

Field Length: 40

This a text field in which a brief remark regarding patient contact may be recorded (i.e., "patient has requested no further contact from registry").

10303 - State of Death

Field Length: 2

Record the 2 character abbreviation for the patient's state of death. See APPENDIX B for alphabetic listings of the appropriate codes and their definitions. Use the most specific code.

Code	Definition
KY	If the state in which the patient died was Kentucky, then use the USPS code for the state of Kentucky
XX	Died in a country other than the U.S. (including it territories, commonwealths, or possessions) or Canada and the country is *known*
YY	Died in a country other than the U.S. (including it territories, commonwealths, or possessions) or Canada and the country is *unknown*
US	Died in the U.S. (including it territories, commonwealths, or possessions) and the state is *unknown*
CD	Died in Canada and the province is *unknown*
ZZ	State of death unknown

10304 - Country of Death

Field Length: 3

Record the 3 character abbreviation for the patient’s country of death. See APPENDIX B for alphabetic listings of the appropriate codes and their definitions. Use the most specific code.

Code 'ZZU' when unknown.

10310 - Number of Primaries

Field Length: 2

This is a field calculated by the computer. It does not appear on the abstract form. However, it is a patient level field that is available for analysis and reporting purposes. It is calculated as the highest sequence number stored for a patient.

10320 - Vital Status

Field Length: 1

This is a field calculated by the computer. It does not appear on the abstract form. However, it is a patient level field that is available for analysis and reporting purposes.

It is calculated from the latest survival status entered for a patient. If Item 31760 (Survival Status) is 1, 2, or 3, then the value in this field is "1" (Alive); if Item 31760 is 4, 5, 6, or 9, then the value in this field is "0" (Dead).

At the central registry, this field may also be assigned through linkages with authoritative sources of vital status information such as Kentucky death certificates or the United States National Death Index.

Code	
1	Alive
0	Dead

10330 - OCCUPATION CODE

Field Length: 3

* **This data item has been retired and is no longer in use***

This field is automatically generated by the computer based on the U.S. Census Bureau code for the patient's occupation.

10340 - INDUSTRY CODE

Field Length: 3

* **This data item has been retired and is no longer in use***

This field is automatically generated by the computer based on the U.S. Census Bureau code for the patient’s usual industry.

10350 - PATIENT DATE OF LAST CONTACT

Field Length: 8

This field is automatically calculated from the most recent date of contact in all cases associated with a patient’s record.

10390 - SEER PATIENT ID

Field Length: 8

This is a unique number assigned to an individual patient by the central registry. KCR will assign the same number to all the patient's subsequent tumor (records).

The SEER Patient ID does not appear on the patient abstract and is not available for analysis.

10410 - IHS Link Status

Field Length: 1

The Indian Health Service (IHS) linkage reports the results of linking the central registry database with the Indian Health Service patient registration database.

The IHS linkage idenitifies American Indians who were misclassified as non-Indian in the registry. The computer linkage program will automatically assign the code for this data item.

Codes

0 Record sent for linkage, no IHS match
1 Record sent for linkage, IHS match
blank Record not sent for linkage or linkage results pending

10420 - LAST MODIFICATION BY

Field Length: 8

This field is calculated by the computer. The user name of the last person to modify patient data is recorded and is updated each time the record is edited.

10430 - LAST MODIFICATION TIME

Field Length: 19

The date and time that patient data was last edited is automatically recorded by the computer.

10440-10530 - Patient User Defined Fields

Field Length: 15 (x 10)

This element provides up to ten fields for coding additional information for each patient. These will be user defined fields based on the individual institution's need or desire to track patterns of diagnostic and treatment procedures, as well as survival, with particular types of cancer patients.

For example:

"a" could be used to code alcohol use.

"b" could be used to code religion

"c" could be used to code exposure to hazardous substances, etc.

10580 - Clinical Trial Type 1

Code the type of clinical trial in which the patient is enrolled.

Code	Type	Description
0	None	Not on any protocol or unknown whether or not on protocol.
1	Diagnostic	Protocol designed to evaluate one of more interventions aimed at identifying a disease or health condition.
2	Health Services Research	Protocol designed to evaluate the delivery, processes, management, organization, or financing of health care.
3	Prevention	Protocol designed to assess one or more interventions aimed at preventing the development of a specific disease or health condition.
4	Screening	Protocol designed to assess or examine methods of identifying a condition (or risk factor for a condition) in people who are not yet known to have the condition (or risk factor)
5	Supportive Care	Protocol designed to evaluate one or more interventions where the primary intent is to maximize comfort, minimize side effects, or mitigate against a decline in the participant's health or function. In general, supportive care interventions are not intended to cure a disease.
6	Basic Science	Protocol designed to examine the basic mechanisms of action (e.g., physiology, biomechanics) of an intervention.
7	Treatment	Protocol designed to evaluate one or more interventions for treating a disease, syndrome, or condition.
8	Other	Protocol other than those described in codes 1-7.
9	Unknown	Patient is enrolled in a clinical trial, but the type of trial is unknown.

10590 - Clinical Trial Accrual Date 1

Enter the month, day, and year the patient was enrolled in this clinical trial.

If the date is unknown, you may enter '99' for the month or day, but you must enter a valid year. If the year is unknown, enter your best estimate.

10600 - Clinical Trial Site Code 1

Choose the site code for the type of cancer involved in clinical trial 1. Use APPENDIX C for site codes.

If the site is unknown or not applicable, use code 55.

10610 - Clinical Trial Text 1

Enter any information here about Clinical Trial 1, such as the trial number, sponsor, design, or purpose. You may also enter information about the patient's clinical trial experience, such as protocol arm, completion date, etc.

10620 - Clinical Trial Type 2

Code the type of clinical trial in which the patient is enrolled.

Code	Type	Description
0	None	Not on any protocol or unknown whether or not on protocol.
1	Diagnostic	Protocol designed to evaluate one of more interventions aimed at identifying a disease or health condition.
2	Health Services Research	Protocol designed to evaluate the delivery, processes, management, organization, or financing of health care.
3	Prevention	Protocol designed to assess one or more interventions aimed at preventing the development of a specific disease or health condition.
4	Screening	Protocol designed to assess or examine methods of identifying a condition (or risk factor for a condition) in people who are not yet known to have the condition (or risk factor)
5	Supportive Care	Protocol designed to evaluate one or more interventions where the primary intent is to maximize comfort, minimize side effects, or mitigate against a decline in the participant's health or function. In general, supportive care interventions are not intended to cure a disease.
6	Basic Science	Protocol designed to examine the basic mechanisms of action (e.g., physiology, biomechanics) of an intervention.
7	Treatment	Protocol designed to evaluate one or more interventions for treating a disease, syndrome, or condition.
8	Other	Protocol other than those described in codes 1-7.
9	Unknown	Patient is enrolled in a clinical trial, but the type of trial is unknown.

10630 - Clinical Trial Accrual Date 2

Enter the month, day, and year the patient was enrolled in this clinical trial.

If the date is unknown, you may enter '99' for the month or day, but you must enter a valid year. If the year is unknown, enter your best estimate.

10640 - Clinical Trial Site Code 2

Choose the site code for the type of cancer involved in clinical trial 2. Use APPENDIX C for site codes.

If the site is unknown or not applicable, use code 55.

10650 - Clinical Trial Text 2

Enter any information here about Clinical Trial 1, such as the trial number, sponsor, design, or purpose. You may also enter information about the patient's clinical trial experience, such as protocol arm, completion date, etc.

10660 - Clinical Trial Type 3

Code the type of clinical trial in which the patient is enrolled.

Code	Type	Description
0	None	Not on any protocol or unknown whether or not on protocol.
1	Diagnostic	Protocol designed to evaluate one of more interventions aimed at identifying a disease or health condition.
2	Health Services Research	Protocol designed to evaluate the delivery, processes, management, organization, or financing of health care.
3	Prevention	Protocol designed to assess one or more interventions aimed at preventing the development of a specific disease or health condition.
4	Screening	Protocol designed to assess or examine methods of identifying a condition (or risk factor for a condition) in people who are not yet known to have the condition (or risk factor)
5	Supportive Care	Protocol designed to evaluate one or more interventions where the primary intent is to maximize comfort, minimize side effects, or mitigate against a decline in the participant's health or function. In general, supportive care interventions are not intended to cure a disease.
6	Basic Science	Protocol designed to examine the basic mechanisms of action (e.g., physiology, biomechanics) of an intervention.
7	Treatment	Protocol designed to evaluate one or more interventions for treating a disease, syndrome, or condition.
8	Other	Protocol other than those described in codes 1-7.
9	Unknown	Patient is enrolled in a clinical trial, but the type of trial is unknown.

10670 - Clinical Trial Accrual Date 3

Enter the month, day, and year the patient was enrolled in this clinical trial.

If the date is unknown, you may enter '99' for the month or day, but you must enter a valid year. If the year is unknown, enter your best estimate.

10680 - Clinical Trial Site Code 3

Choose the site code for the type of cancer involved in clinical trial 3. Use APPENDIX C for site codes.

If the site is unknown or not applicable, use code 55.

10690 - Clinical Trial Text 3

Enter any information here about Clinical Trial 1, such as the trial number, sponsor, design, or purpose. You may also enter information about the patient's clinical trial experience, such as protocol arm, completion date, etc.

10700 - Clinical Trial Type 4

Code the type of clinical trial in which the patient is enrolled.

Code	Type	Description
0	None	Not on any protocol or unknown whether or not on protocol.
1	Diagnostic	Protocol designed to evaluate one of more interventions aimed at identifying a disease or health condition.
2	Health Services Research	Protocol designed to evaluate the delivery, processes, management, organization, or financing of health care.
3	Prevention	Protocol designed to assess one or more interventions aimed at preventing the development of a specific disease or health condition.
4	Screening	Protocol designed to assess or examine methods of identifying a condition (or risk factor for a condition) in people who are not yet known to have the condition (or risk factor)
5	Supportive Care	Protocol designed to evaluate one or more interventions where the primary intent is to maximize comfort, minimize side effects, or mitigate against a decline in the participant's health or function. In general, supportive care interventions are not intended to cure a disease.
6	Basic Science	Protocol designed to examine the basic mechanisms of action (e.g., physiology, biomechanics) of an intervention.
7	Treatment	Protocol designed to evaluate one or more interventions for treating a disease, syndrome, or condition.
8	Other	Protocol other than those described in codes 1-7.
9	Unknown	Patient is enrolled in a clinical trial, but the type of trial is unknown.

10710 - Clinical Trial Accrual Date 4

Enter the month, day, and year the patient was enrolled in this clinical trial.

If the date is unknown, you may enter '99' for the month or day, but you must enter a valid year. If the year is unknown, enter your best estimate.

10720 - Clinical Trial Site Code 4

Choose the site code for the type of cancer involved in clinical trial 4. Use APPENDIX C for site codes.

If the site is unknown or not applicable, use code 55.

10730 - Clinical Trial Text 4

Enter any information here about Clinical Trial 1, such as the trial number, sponsor, design, or purpose. You may also enter information about the patient's clinical trial experience, such as protocol arm, completion date, etc.

Case and FU Data

20030 - SEQUENCE NUMBER (Other Primary)

Field Length: 2

This field is for recording a history of cancer that was not diagnosed or treated at your hospital. It may also be used to record a subsequent primary which occurs in one of your cancer patients but is not diagnosed or treated by your hospital.

The sequence number represents the order of all reportable primary tumors diagnosed during a patient's lifetime. It counts the occurrence of independent, primary diagnoses, regardless of who must report them, but only if diagnosed in years for which that condition was considered reportable. Thus, it does not include skin malignancies and carcinoma in-situ of the cervix, diagnosed in years when they were not reportable, BUT it does include benign and borderline intracranial tumors diagnosed before 2004.

Enter the number which designates the chronological order of this primary tumor which is not reportable by your hospital.

1 - 1st primary
2 - 2nd primary
3 - 3rd primary
... etc.

Single digits will automatically be right justified in the computer.

This field may be repeated as often as necessary for any given patient.

20040 - SITE GROUP (Other Primary)

Field Length: 2

Record the two digit code for the site group into which this primary malignancy is categorized. Use Appendix C to determine the appropriate site group, based on the anatomic site and histology mentioned.

Site group code "55" is available only for 'Other Primaries' if you cannot determine to which site group the malignancy is coded. If 'lung cancer' is all that is known, code "23" for non-small cell lung.

Starting in 2004, site group 60 is assigned for all benign and borderline intracranial tumors.

20050 - YEAR OF DIAGNOSIS (Other Primary)

Field Length: 4

Record the year of diagnosis for the other primary. If the year of diagnosis is unknown, use 9999.

20060 - Comment (Other Primary)

Field Length: 30

Enter a brief description of the primary which is not reportable by your institution. You may wish to include information regarding topography, histology, date of diagnosis, the location where this primary was diagnosed or treated, or the reason the case is not reportable by your registry.

20070 - LAST MODIFICATION BY (Other Primary)

Field Length: 8

The user name of the person who last edited the case type "O" is recorded by the computer in this field.

20080 - LAST MODIFICATION TIME (Other Primary)

Field Length: 19

The computer automatically records the date and time the case type "O" record was edited.

30030 - SEQUENCE NUMBER

Field Length: 2

The sequence number represents the order of all primary reportable tumors diagnosed during a patient's lifetime. It counts the occurrence of independent, primary diagnoses, regardless of who must report them, but only if diagnosed in years in which they were considered reportable. Thus, it does not include skin malignancies and carcinoma in-situ of the cervix diagnosed in years when they were not considered reportable.

> **Exception:** Benign and borderline CNS tumors are sequenced to include historical tumors, including those diagnosed prior to 2004.

Enter the number which designates the chronological order of this primary tumor in relation to all primary tumors (including in-situ) that the patient has had. (Single digits will be right justified by the computer.)

1 - 1st primary
2 - 2nd primary
3 - 3rd primary
4 - 4th primary
5 - 5th primary
6 - 6th primary
7 - 7th primary
8 - 8th primary
9 - 9th primary
... (and so on)

For patients having more than one independent, reportable primary diagnosed at the same time, the selection of the first is assigned to the primary with the worst prognosis. If no difference in prognosis is evident, the selection of the sequence number may be arbitrary.

Only include reportable conditions, as outlined earlier.

30040 - SITE GROUP

Field Length: 2

A two digit code for the site group into which this primary malignancy is categorized will be calculated by the computer. Appendix C shows the appropriate site groups, based on the anatomic site and histology mentioned for this case.

Starting in 2004, site group 60 is assigned for all benign and borderline intracranial tumors.

30050 - CASE TYPE

Field Length: 1

This field indicates whether a case will be entered into the database as a full abstract (case type A) or as an "other" primary (case type O). Use case type O only for primaries that are collected by KCR but which are not reportable by your registry.

30060 - ICD-O VERSION

Field Length: 1

Enter the appropriate code for the version of ICD-O which was used to determine the topography and morphology codes entered in items 32 and 33.

Code	Description
1	ICD-O, 1st edition (1976)
F	ICD-O, Field Trial edition (1988)
2	ICD-O, 2nd Edition (1990)
3	ICD-O, 3rd Edition (2001)

All cases diagnosed before January 1, 2001 should be coded with the ICD-O, 2nd edition used to determine the topography and morphology codes.

All cases diagnosed on or after January 1, 2001 should be coded 3, with the 3rd edition used to determine the topography and morphology codes.

In the computerized record, all cases will have the ICD-O-3 topography, histology and behavior codes stored. Cases diagnosed prior to 2001 will have the ICD-O-2 histology and behavior codes stored as well.

See also "ICD-O-3 Errata and Clarifications" in APPENDIX J, to be used when abstracting cases diagnosed after January 1, 2001.

30070 - ICD-O-3 CONVERSION FLAG

Field Length: 1

Record the one digit code specifying how the conversion of site and morphology codes from ICD-O-2 to ICD-O-3 was accomplished.

Code	Description
0	Primary site and morphology originally coded in ICD-O-3
1	Primary site and morphology converted without review
3	Primary site computer-converted without review; morphology converted with review

If the diagnosis date is prior to January 1, 2001, the case record must have:

* an ICD-O-2 histology and behavior codes
* a conversion flag value of 1 or 3

The computer will automatically convert the ICD-O-2 codes to the ICD-O-3 codes if the conversion flag is 1.

If the diagnosis date is on or after January 1, 2001, the case record must have:

* ICD-O-3 histology and behavior codes
* a conversion flag of 0
* blanks in the ICD-O-2 field

ICD-O-3 Conversion Flag Controls Field Editing

0 Originally coded in ICD-O-3
(cursor goes only to ICD-O-3 histology)

1 ICD-O-2 code converted without review
(cursor goes only to ICD-O-2 histology)

3 ICD-O-2 converted with review
(cursor goes only to ICD-O-3 histology)

30080 - TOPOGRAPHY CODE

Field Length: 5

Enter the ICD-O 3rd edition Topography code which describes the anatomical site of the patient's primary tumor. This is a five character field. After the "C", enter the three digit code; the decimal point is already in the correct position.

The International Classification of Diseases for Oncology (ICD-O) 3rd edition, represents an extension of Chapter II of the ICD-10 coding reference. ICD-O permits the coding of all neoplasms by topography, morphology, and cell behavior -- providing greater detail than that permitted with ICD-9 or ICD-10 coding schemes.

The structure of the ICD-O reference book contains three major sections:

Topography - A numerical list of anatomic sites adapted from the malignant neoplasms section of Chapter II of ICD-10. The topographic terms have 3-digit code numbers preceded by a "C" which run from C00.0 to C80.9.

Morphology - A numerical list of histologic terms that is a revised and expanded version of the morphology section of The Manual of Tumor Nomenclature and Coding. The ICD-O, 3rd edition includes new histologic types that have come into the literature since 1990. It has revised the Leukemia and Lymphoma sections and now includes several hematopoietic diseases that were previously considered borderline.

Alphabetic Index - A list of anatomic sites, histologic terms and selected tumor-like lesions and conditions.

Refer to the introductory pages of the International Classification of Diseases for Oncology, 3rd edition, for a more detailed discussion of the differences between ICD-O and ICD-10, as well as for rules governing the appropriate assignment of ICD-O codes. See also APPENDIX J for errata and clarifications to ICD-O-3rd edition.

Coding Instructions for Solid Tumors

Site-Specific Topography Terms

See the Coding Guidelines for Topography and Morphology in the introduction of the ICD-O-3 for additional details.

1. Unless otherwise instructed, use all available information to code the site.

2. Code the site in which the primary tumor originated, even if it extends onto/into an adjacent subsite.

Example 1: Final diagnosis is adenocarcinoma of the upper lobe of the right lung. Code the topography to lung, upper lobe (C341).

Example 2: The patient has a 4 cm tumor in the right breast. The tumor originated in the upper inner quadrant and extends into the lower inner quadrant. Code the primary site to upper inner quadrant of breast (C502).

Example 3: Patient has a right branchial cleft cyst; the pathology report identifies an adenocarcinoma arising in an ectopic focus of thyroid tissue within the branchial cleft cyst. Thyroidectomy pathology is negative. Code the primary site to branchial cleft (C104).

Example 4: The patient had a total hysterectomy with a bilateral salpingo-oophorectomy ten years ago for non-cancer reasons. She now has widespread cystadenocarcinoma in the peritoneum. Code the primary site to peritoneum, NOS (C482). (The chart may or may not state that the patient has extra-ovarian carcinoma.)

Example 5: Pathology report shows adenocarcinoma arising in a patch of endometriosis on the sigmoid colon. Code the primary site to sigmoid colon (C187), the site in which the cancer originated.

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

Example: The patient has a 5cm tumor that involves the dorsal surface and anterior 2/3 of tongue. Code the primary site to C028 (overlapping lesion of tongue).

4. Code the site of the invasive tumor when there is an invasive tumor and in situ tumor in different subsites of the same anatomic site.

Example 1: Patient has an invasive breast tumor in the upper-outer quadrant of the left breast and in situ tumor in multiple quadrants of the left breast. Code the primary site to C504 (upper outer quadrant of breast).

Example 2: Patient has in situ Paget disease of the right nipple and invasive duct carcinoma of the lower inner quadrant of the right breast. Code the primary site to C503 (lower inner quadrant).

5. Code the last digit of the primary site code to '9' for single primaries, when multiple tumors arise in different subsites of the same anatomic site and the point of origin cannot be determined.

   Example 1: During a TURB, the physician describes multiple papillary tumors in the bladder neck (C675) and the lateral wall of the bladder (C672). Code the primary site as bladder, NOS (C679).

   Example 2: Patient has an infiltrating duct tumor in the upper outer quadrant (C504) of the right breast and another infiltrating duct carcinoma in the lower inner (C503) quadrant of the right breast. Code the primary site as breast, NOS (C509).

6. Some histology/behavior terms in ICD-O-3 have a related site code in parentheses; for example: Hepatoma (C220).

   a. Code the site as documented in the medical record and ignore the suggested ICD-O-3 code when a primary site is specified in the medical record.

      Example: The pathology report says "infiltrating duct carcinoma of the head of the pancreas." The listing in ICD-O-3 is infiltrating duct carcinoma 8500/3 (C50_). Code the primary site to head of pancreas (C250), NOT to breast (C50_) as suggested by the ICD-O-3.

   b. Use the site code suggested by ICD-O-3 when the primary site is the same as the site code suggested or the primary site is unknown

      Example 1: The biopsy is positive for hepatoma, and no information is available about the primary site. Code the primary site to liver (C220) as suggested by ICD-O-3.

      Example 2: An excision of the right axillary nodes reveals metastatic infiltrating duct carcinoma. The right breast is negative. The ICD-O-3 shows infiltrating duct carcinoma (8500) with a suggested site of breast (C50_). Code the primary site as breast, NOS (C509).

7. Code the primary site, not the metastatic site. If a tumor is metastatic and the primary site is unknown, code the primary site as unknown (C809).

8. See the site-specific Coding Guidelines in Appendix C for primary site coding guidelines for the following sites:

Bladder	Kaposi sarcoma
Breast	Lung
Colon	Rectosigmoid, rectum
Esophagus	

9. See below for primary site coding guidelines for Sarcoma.
10. Code C422 (Spleen) as the primary site for angiosarcoma of spleen with mets to bone marrow.
11. Gastrointestinal Stromal Tumors (GIST): Code the primary site to the location where the malignant GIST originated.
12. In the ***absence of any additional information***, assign the codes listed for these primary sites

Code	Primary site
C445	Anal margin
C162	Angle of the stomach
C068	Book-leaf lesion (mouth)
C000	Colored / lipstick portion of upper lip
C720	Distal conus
C021	Edge of tongue
C718	Frontoparietal (brain)
C163	Gastric angular notch
C349	Infrahilar area of lung
C709	Leptomeninges
C069	Masticatory space
C446	Nail bed. thumb
C269	Pancreatobiliary
C490	Parapharyngeal space
C240	Perihilar bile duct

13. When the medical record does not contain enough information to assign a primary site:
    a. Consult a physician advisor to assign the site code.

b. Use the NOS category for the organ system or the Ill-Defined Sites (C760-C768) if the physician advisor cannot identify a primary site.

c. Code Unknown Primary Site (C809) if there is not enough information to assign an NOS or Ill-Defined Site category.

Sarcoma

The majority of sarcomas arise in mesenchymal or connective tissues that are located in the musculoskeletal system, which includes the fat, muscles, blood vessels, deep skin tissues, nerves, bones, and cartilage. The default code for sarcomas of unknown primary site is C499 rather than C809.

Sarcomas may also arise in the walls of hollow organs and in the viscera covering an organ. Code the primary site to the organ of origin.

Example: The pathology identifies a carcinosarcoma of the uterine corpus. Code the primary site to corpus uteri (C549).

Coding Instructions for Hematopoietic and Lymphoid Neoplasms (9590/3-9992/3)

See the Hematopoietic Manual and Database for instructions on coding the primary site for hematopoietic and lymphoid neoplasms.

30090 - HISTOLOGY

Field Length: 4

Instructions for Coding

- Record histology using the ICD-O-3 codes in the Numeric Lists/Morphology section (ICD-O-3, pp. 69-104) and in the Alphabetic Index (ICD-O-3, pp. 105-218).
- Follow the coding rules outlined on pages 20 through 40 of ICD-O-3.
- Use the SEER 2007 Multiple Primary and Histology Coding Rules when coding the histology for reportable solid malignant tumors. These rules are effective for cases diagnosed January 1, 2007, or later. Do not use these rules to abstract cases diagnosed prior to this date; for these cases, see the section below entitled "Rules for Coding Histology Prior to 2007."
- Use the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database* when coding histology for reportable hematopoietic and lymphoid malignancies diagnosed January 1, 2010 onward. NOTE: The Hematopoietic Database contains additional histologies which are not found in ICD-O-3, but are valid for use from 2010 forward.
- Review all pathology reports.
- Code the **final** pathologic diagnosis.

  EXCEPTION: If the final diagnosis is "Not Otherwise Specified" (carcinoma, NOS; melanoma, NOS; sarcoma, NOS; lymphoma, NOS; or malignant tumor, NOS), then code the histology from the microscopic description or comment if it identifies a more specific histologic type (higher ICD-O-3 code) such as adenocarcinoma, amelanotic melanoma, or spindle cell sarcoma.

- The codes for cancer, NOS (8000) and carcinoma, NOS (8010) are **not** interchangeable. If the physician says that the patient has carcinoma, then code carcinoma, NOS (8010).
- Note that the determination of multiple primaries for benign and borderline intracranial and CNS tumors is based on histologic groupings. See the table and rules below for histologic groupings for non-malignant brain and CNS tumors.
- See Table of Specific Histologies that should not be coded to ill-defined sites (C76._).

Rules for Coding the Histology of Solid Tumors Diagnosed Prior to 2007

Coding Instructions

Use all of the information for a single primary to code the histology.

1. If there is no tumor specimen, code the histology described by the medical practitioner.
2. Use the histology stated in the **final diagnosis** from the pathology report. Use the pathology from the procedure that resected the majority of the primary tumor.

If a more specific histologic type is definitively described in the microscopic portion of the pathology report or the comment, code the more specific diagnosis.

3. Cases reported to KCR cannot have a metastatic (/6) behavior code. If the only pathology specimen is from a metastatic site, code the appropriate histology code and the malignant behavior code /3. The primary site and its metastatic site(s) have the same basic histology.

Histology Coding Rules for Single Tumor

- The rules are in hierarchical order. Rule 1 has the highest priority.
- Use the rules in priority order.
- Use the first rule that applies to the case. (Do not apply any additional rules.)

1. Code the histology if only one type is mentioned in the pathology report.
2. Code the **invasive histology** when both invasive and in situ tumor are present.

   Example: Pathology report reads infiltrating ductal carcinoma and cribriform ductal carcinoma insitu. Code the invasive histology 8500/3.

   Exception: If the histology of the invasive component is an 'NOS' term (e.g., carcinoma, adenocarcinoma, melanoma, sarcoma), then code the histology of the specific term associated with the insitu component and an invasive behavior code.
3. Use a **mixed** histology code if one exists

   Examples of mixed codes: (This is not a complete list, these are examples only)

   8490 Mixed tumor, NOS
   9085 Mixed germ cell tumor
   8855 Mixed liposarcoma
   8990 Mixed mesenchymal sarcoma
   8951 Mixed mesodermal tumor
   8950 Mixed Müllerian tumor
   9362 Mixed pineal tumor
   8940 Mixed salivary gland tumor, NOS
   9081 Teratocarcinoma, mixed embryonal carcinoma and teratoma
4. Use a **combination** histology code if one exists

   Examples of combination codes: (This is not a complete list; these are examples only)

   8255 Renal cell carcinoma, mixed clear cell and chromophobe types
   8523 Infiltrating duct carcinoma mixed with other types of carcinoma
   8524 Infiltrating lobular carcinoma mixed with other types of carcinoma
   8560 Adenosquamous carcinoma
   8045 Combined small cell carcinoma, combined small cell-large cell
5. Code the **more specific term** when one of the terms is 'NOS' and the other is a more specific description of the same histology.

   Example 1: Pathology report reads poorly differentiated carcinoma, probably squamous in origin. Code the histology as squamous cell carcinoma rather than the non-specific term "carcinoma."

   Example 2: The pathology report from a nephrectomy reads renal cell carcinoma (8312) (renal cell identifies the affected organ system rather than the histologic cell type) in one portion of the report and clear cell carcinoma (8310) (a histologic cell type) in another section of the report. Code clear cell carcinoma (8310); renal cell carcinoma (8312) refers to the renal system rather than the cell type, so renal cell is the less specific code.

6. Code the **majority** of tumor.
   a. Based on the pathology report description of the tumor.
   b. Based on the use of majority terms. See definition for majority terms.

Terms that mean the majority of tumor	Terms that DO NOT mean the majority of tumor
Predominantly	With foci of
With features of	Focus of/focal
Major	Areas of
Type[1]	Elements of
With.....Differentiation[1]	Component[1]
Pattern (Only if written in College of American Pathologists [CAP] Protocol)[2]	
Architecture (Only if written in College of American Pathologists [CAP] Protocol)[2]	

Note: Examples of CAP protocols for specific primary sites may be found on the website: http://www.cap.org/apps/docs/cancer_protocols/protocols_index.html

7. Code the **numerically higher** ICD-O-3 code. This is the rule with the lowest priority and should be used infrequently.

Histology Coding Rules for Multiple Tumors with Different Behaviors in Same Organ Reported as a Single Primary

1. Code the histology of the invasive tumor when one lesion is in situ (/2) and the other is invasive (/3).
   Example: At mastectomy for removal of a 2 cm invasive ductal carcinoma, an additional 5 cm area of intraductal carcinoma was noted. Code histology and behavior as invasive ductal carcinoma (8500/3).

Histology Coding Rules for Multiple Tumors in Same Organ Reported as a Single Primary

1. Code the histology when multiple tumors have the same histology.
2. Code the histology to adenocarcinoma (8140/_; in situ or invasive) when there is an adenocarcinoma and an adenocarcinoma in a polyp (8210/_, 8261/_, 8263/) in the same segment of the colon or rectum.
3. Code the histology to carcinoma (8010/_; in situ or invasive) when there is a carcinoma and a carcinoma in a polyp (8210/_) in the same segment of the colon or rectum.
4. Use a **combination** code for the following:
   a. Bladder: Papillary and urothelial (transitional cell) carcinoma (8130)
   b. Breast: Paget Disease and duct carcinoma (8541)

c. Breast: Duct carcinoma and lobular carcinoma (8522)

d. Thyroid: Follicular and papillary carcinoma (8340)

5. Code the more specific term when one of the terms is 'NOS' and the other is a more specific description of the same histology.

6. Code all other multiple tumors with different histologies as multiple primaries.

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

When there are **multiple tumors**, use the following table to determine if the tumors are the same histology or different histologies.

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

Rules for Using Histologic Group Table for Non-Malignant Brain Tumors

1. If **both** histologies are listed in the table, then

a. Histologies that are in the same grouping or row in the table are the **same** histology.

Note: Histologies that are in the same grouping are a progression, differentiation or subtype of a single histologic category.

b. Histologies listed in different groupings (or rows) in the table are **different** histologies

2. If one or both of the histologies is **not** listed in the table**,** then

a. If the ICD-O-3 codes for both histologies have the **identical** first three digits, the histologies are the **same**.

b. If the first three digits of the **ICD-O-3** histology code are **different**, the histology types are different.

Specific Histologies with Ill-Defined Sites

If any of the following histologies appears only with an ill-defined site description (e.g., "abdominal" or "arm"), code it to the tissue in which such tumors arise rather than the ill-defined region (C76._) of the body, which contains multiple tissues.

Histology	Description	Code to this Site
8720-8790	Melanoma	C44._, Skin
8800-8811, 8813-8830, 8840-8921, 9040-9044	Sarcoma except periosteal fibrosarcoma and dermatofibrosarcoma	C49._, Connective, Subcutaneous and Other Soft Tissues
8990-8991	Mesenchymoma	C49._, Connective, Subcutaneous and Other Soft Tissues
9120-9170	Blood vessel tumors, lymphatic vessel tumors	C49._, Connective, Subcutaneous and Other Soft Tissues
9580-9582	Granular cell tumor and alveolar soft part sarcoma	C49._, Connective, Subcutaneous and Other Soft Tissues
9240-9252	Mesenchymal chondrosarcoma and giant cell tumors	C40._, C41._ for Bone and Cartilage C49._, Connective, Subcutaneous and Other Soft Tissues
8940-8941	Mixed tumor, salivary gland type	C07._ for Parotid Gland C08._ for Other and Unspecified Major Salivary Glands

Refer to the introductory pages of the International Classification of Diseases for Oncology, 3rd edition, for a more detailed discussion of the rules governing the appropriate assignment of ICD-O codes. See also APPENDIX J for errata and clarifications to ICD-O-3rd edition.

30100 - BEHAVIOR CODE

Field Length: 1

Record the behavior of the tumor being reported. The fifth digit of the morphology code is the behavior code.

Instructions for Coding

- Code 3 if any invasion is present, no matter how limited.
- If the specimen is from a metastatic site, code the histology of the metastatic site and code 3 for behavior
- Gastro-intestinal stromal tumors (GIST) and thyomas are frquently non-malignant. However, they must be abstracted and assigned a Behavior Code of 3 if they are noted to have multiple foci, metastasis, or positive lymph nodes.

Note: The ICD-O-3 behavior code for juvenile astrocytoma (9421/1) is coded as 3. Refer to the section "Case Reporting Requirements."

Code	Label	Description
0	Benign	Benign
1	Borderline	Uncertain whether benign or malignant
		Borderline malignancy
		Uncertain malignant potential
2	In situ and/or carcinoma in situ	Adenocarcinoma in an adenomatous polyp with no invasion of stalk
		Clark level 1 for melanoma (limited to epithelium)
		Comedocarcinoma, noninfiltrating (C50._)
2	Synonymous with in situ	Confined to epithelium
		Hutchinson melanotic freckle, NOS (C44._)
		Intracystic, noninfiltrating
		Intraductal
		Intraepidermal, NOS
		Intraepithelial, NOS
		Involvement up to, but not including the basement membrane
		Lentigo maligna (C44._)
		Lobular neoplasia (C50._)
		Lobular, noninfiltrating (C50._)
		Noninfiltrating
		No stromal involvement
		Papillary, noninfiltrating, or intraductal
		Precancerous melanosis (C44._)
		Queyrat erythroplasia (C60._)

		AIN III (C21.1)
		LIN III (C32.0-C32.9)
		SIN III (squamous intraepithelial neoplasia)
		VAIN III (C52.9)
		VIN III (C51._)
		Bowen disease (not reportable for C44._)
3	Invasive	Invasive or microinvasive

30110 - Histology (ICD-O-2)

Field Length: 4

This field is only completed for cases diagnosed prior to January 1, 2001. For those cases, record the appropriate four digit histology code from the ICD-O, 2nd edition which describes the histologic type of this reportable condition.

30120 - Behavior Code (ICD-O-2)

Field Length: 1

This field is only completed for cases diagnosed prior to January 1, 2001. The fifth digit of the ICD-O-2 morphology code is the behavior code. Record the behavior of the tumor being reported

30130 - TUMOR GRADE/DIFFERENTIATION

Field Length: 1

CODING INSTRUCTION FOR 2014+

GRADE, DIFFERENTIATION OR CELL INDICATOR
Item Length: 1 NAACCR
Item #: 440
NAACCR Name: Grade

Grade, Differentiation for solid tumors (Codes 1, 2, 3, 4, 9) and Cell Indicator for Lymphoid Neoplasms (Codes 5, 6, 7, 8, 9)
Note: These instructions pertain to the data item Grade, Differentiation or Cell Indicator. These are coding instructions for cases diagnosed 1/1/2014 and forward.

Hematopoietic and Lymphoid Neoplasms
Cell Indicator (Codes 5, 6, 7, 8, 9)
Cell Indicator (Codes 5, 6, 7, 8) describes the lineage or phenotype of the cell. Codes 5, 6, 7, and 8 are used only for hematopoietic and lymphoid neoplasms. Code 9 indicates cell type not determined, not stated, or not applicable.

Coding Grade for Hematopoietic and Lymphoid Neoplasms

1. Determine the histology based on the current Hematopoietic and Lymphoid Neoplasm Manual [http://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules/].

2. Determine the Cell Indicator by applying the "Grade of Tumor Rules" within the current Hematopoietic and Lymphoid Neoplasm Manual [http://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules/] to code the grade.

Grade codes for hematopoietic and lymphoid neoplasms

T-cell; T-precursor	5
B-Cell; Pre-B; B-precursor	6
Null cell; Non T-non B	7
NK cell (natural killer cell)	8
Grade unknown, not stated, or not	9

Solid Tumors

Grade, Differentiation (Codes 1, 2, 3, 4, 9)

Pathologic examination determines the grade, or degree of differentiation, of the tumor. For these cancers, the grade is a measurement of how closely the tumor cells resemble the parent tissue (organ of origin). Well-differentiated tumor cells closely resemble the tissue from the organ of origin. Poorly differentiated and undifferentiated tumor cells are disorganized and abnormal looking; they bear little (poorly differentiated) or no (undifferentiated) resemblance to the tissue from the organ of origin. These similarities/differences may be based on pattern (architecture), cytology, nuclear (or nucleolar) features, or a combination of these elements, depending upon the grading system that is used. Some grading systems use only pattern, for example Gleason grading in prostate. Others use only a nuclear grade (usually size, amount of chromatin, degree of irregularity, and mitotic activity). Fuhrman's grade for kidney is based only on nuclear features. Most systems use a combination of pattern and cytologic and nuclear features; for example Nottingham's for breast combines numbers for pattern, nuclear size and shape, and mitotic activity. The information from this data item is useful for determining prognosis and treatment.

Pathologists describe the tumor grade using three systems or formats:

1. Two levels of similarity; also called a two-grade system
2. Three levels of similarity; also called a three-grade system (code according to "Coding for solid tumors."
    a. Grade I, well
    b. Grade II, moderately
    c. Grade III, poorly (undifferentiated carcinoma is usually separated from this system, since "poorly" bears some, albeit little, similarity to the host tissue, while "undifferentiated" has none, e.g. Undifferentiated carcinoma).
3. Four levels of similarity; also called a four-grade system. The four-grade system describes the tumor as
    a. Grade I; also called well-differentiated
    b. Grade II; also called moderately differentiated
    c. Grade III; also called poorly differentiated
    d. Grade IV; also called undifferentiated or anaplastic

Breast and prostate grades may convert differently than other sites. These exceptions are noted in "Coding for Solid Tumors", #7-8 below.

Coding for Solid Tumors

1. Systemic treatment and radiation can alter a tumor's grade. Therefore, it is important to code grade based on information prior to neoadjuvant therapy even if grade is unknown.
2. Code the grade from the primary tumor only.
    a. Do NOT code grade based on metastatic tumor or recurrence. In the rare instance that tumor tissue extends contiguously to an adjacent site and tissue from the primary site is not available, code grade from the contiguous site.
    b. If primary site is unknown, code grade to 9.
3. Code the grade shown below (6th digit) for specific histologic terms that imply a grade.
    Carcinoma, undifferentiated (8020/34)
    Carcinoma, anaplastic (8021/34)

Follicular adenocarcinoma, well differentiated (8331/31)
Thymic carcinoma, well differentiated (8585/31)
Sertoli-Leydig cell tumor, poorly differentiated (8631/33)
Sertoli-Leydig cell tumor, poorly differentiated with heterologous elements (8634/33)
Undifferentiated sarcoma (8805/34)
Liposarcoma, well differentiated (8851/31)
Seminoma, anaplastic (9062/34)
Malignant teratoma, undifferentiated (9082/34)
Malignant teratoma, intermediate type (9083/32)
Intraosseous osteosarcoma, well differentiated (9187/31)
Astrocytoma, anaplastic (9401/34)
Oligodendroglioma, anaplastic (9451/34)
Retinoblastoma, differentiated (9511/31)
Retinoblastoma, undifferentiated (9512/34)

4. In situ and/or combined in situ/invasive components:
   a. If a grade is given for an in situ tumor, code it. Do NOT code grade for dysplasia such as high grade dysplasia.
   b. If there are both in situ and invasive components, code only the grade for the invasive portion even if its grade is unknown.
5. If there is more than one grade, code the highest grade within the applicable system. Code the highest grade even if it is only a focus. Code grade in the following priority order using the first applicable system:
   a. special grade systems for the sites listed in Coding for Solid Tumors #6
   b. differentiation: use Coding for Solid Tumors #7: 2-, 3-, or 4- grade system
   c. nuclear grade: use Coding for Solid Tumors #7: 2-, 3-, or 4- grade system
   d. If it isn't clear whether it is a differentiation or nuclear grade and a 2-, 3-, or 4-grade system was used, code it.
   e. Terminology (use Coding for Solid Tumors #8)
6. Use the information from the special grade systems first. If no special grade can be coded, continue with Coding for Solid Tumors #7-9.

Special grade systems for solid tumors

Grade information based on CS Site-specific factors for breast, prostate, heart, mediastinum, peritoneum, retroperitoneum, soft tissue, and kidney parenchyma is used to code grade. See Special Grade System Rules section below for details on how to use this information to code grade.

CS Schema	Special grade system
Breast	Nottingham or Bloom-Richardson (BR) Score/Grade (SSF7)
Prostate	Gleason's Score on Needle Core Biopsy/Transurethral Resection of Prostate (TURP) (SSF 8)
Prostate	Gleason's Score on Prostatectomy/Autopsy (SSF 10)
Heart,	Grade for Sarcomas (SSF 1)

Peritoneum	Grade for Sarcomas (SSF 1)
Retroperitoneum	Grade for Sarcomas (SSF 1)
Soft Tissue	Grade for Sarcomas (SSF 1)
Kidney	Fuhrman Nuclear Grade (SSF 6)

7. Use the Two-, Three- or Four-grade system information

a. Two-grade system

Term	Description	Grade Code	Exception for Breast and Prostate Grade Code
1/2, I/II	Low grade	2	1
2/2,	High grade	4	3

In transitional cell carcinoma for bladder, the terminology high grade TCC and low grade TCC are coded in the two-grade system.

b. Three-grade system

			Exception for Breast and
1/3	Low grade	2	1
2/3	Intermediate	3	2
3/3	High grade	4	3

c. Four-grade system: Any four-gradesystem includingEdmondson and Steiner grade for liver.

Term	Description	Grade Code
1/4	Grade I; Well differentiated	1
2/4	Grade II; Moderately differentiated	2
3/4	Grade III; Poorly differentiated	3
4/4	Grade IV; Undifferentiated	4

8. Terminology: use the ‘Description’ column or the ‘Grade’ column to code grade. Breast & Prostate use the same grade code with a few noted exceptions.

Description	Grade	Assign Grade Code	Exception for Breast and Prostate Grade Code
Differentiated, NOS	I	1	
Well differentiated	I	1	
Only stated as ‘Grade I’	I	1	
Fairly well differentiated	II	2	
Intermediate differentiation	II	2	

Low grade	I-II	2	1
Mid differentiated	II	2	
Moderately differentiated	II	2	
Moderately well differentiated	II	2	
Partially differentiated	II	2	
Partially well differentiated	I-II	2	1
Relatively or generally well differentiated	II	2	
Only stated as 'Grade II'	II	2	
Medium grade, intermediate grade	II-III	3	2
Moderately poorly differentiated	III	3	
Moderately differentiated	III	3	
Poorly differentiated	III	3	
Relatively poorly differentiated	III	3	
Relatively undifferentiated	III	3	
Slightly differentiated	III	3	
Dedifferentiated	III	3	
Only stated as 'Grade III'	III	3	
High grade	III-IV	4	3
Undifferentiated, anaplastic, not	IV	4	
Only stated as 'Grade IV'	IV	4	
Non-high grade		9	

9. If no description fits or grade is unknown prior to neoadjuvant therapy, code as a 9 (unknown).

SPECIAL GRADE SYSTEMS RULES

Breast (site: breast excluding lymphomas; CS schema: breast)

Use Bloom Richardson (BR) or Nottingham score/grade to code grade based on CSv2 site-specific factor 7 (SSF) as stated below. If your registry does not collect this SSF, use the description in the table below to determine grade. If you collect this SSF, codes 030-130 could be automatically converted into the grade field.

BR could also be referred to as: Bloom-Richardson, modified Bloom-Richardson, BR, BR grading, Scarff-Bloom-Richardson, SBR grading, Elston-Ellis modification of Bloom-Richardson score, Nottingham modification of Bloom-Richardson score, Nottingham modification of Scarff-Bloom-Richardson, Nottingham-Tenovus grade, or Nottingham grade.

Code the tumor grade using the following priority order

a. BR scores 3-9
b. BR grade (low, intermediate, high)

BR score may be expressed as a range, 3-9. The score is based on three morphologic features: degree of tubule formation/histologic grade, mitotic activity, nuclear pleomorphism/nuclear grade of tumor cells. If a report uses words such as low, intermediate, or high rather than numbers, use the table below to code grade.

If only a grade of 1 through 4 is given with no information on the score and it is unclear if it is a Nottingham or BR Grade, do not use the table below. Continue with the next priority according to "Coding for Solid Tumors" #7 above.

Code the highest score if multiple scores are reported (exclude scores from tests after neoadjuvant therapy began). Examples: different scores may be reported on multiple pathology reports for the same primary cancer; different scores may be reported for multiple tumors assigned to the same primary cancer.

CS Site-Specific Factor 7
Nottingham or Bloom-Richardson (BR) Score/Grade

Description	CS Code	Grade Code
Score of 3	030	1
Score of 4	040	1
Score of 5	050	1
Score of 6	060	2
Score of 7	070	2
Score of 8	080	3
Score of 9	090	3
Low Grade, Bloom-Richardson (BR) grade 1, score not given	110	1
Medium (Intermediate) Grade, BR grade 2, score not given	120	2
High Grade, BR grade 3, score not given	130	3

Kidney Parenchyma (Site: kidney parenchyma excluding lymphomas; CS schema: KidneyParenchyma): Fuhrman Nuclear Grade
The Fuhrman Nuclear Grade should be used to code grade for kidney parenchyma only based on CSv2 SSF 6 as stated below. Do not use for kidney renal pelvis. If your registry does not collect this SSF, use the description in the table to determine grade. If you collect this SSF, the information could be automatically converted into the grade field if it is coded 010-040. Fuhrman nuclear grade is a four-grade system based on nuclear diameter and shape, the prominence of nucleoli, and the presence of chromatin clumping in the highest grade.

Description	CS Code	Grade Code
Grade 1	010	1
Grade 2	020	2

Grade 3	030	3
Grade 4	040	4

SoftTissue (sites excluding lymphomas: soft tissue, heart, mediastinum, peritoneum, and retroperitoneum; for CS users: SoftTissue, HeartMediastinum, Peritoneum, Retroperitoneum schemas): Grade for Sarcomas

The Grade for Sarcomas should be used to code grade based on CSv2 SSF 1 as stated below. If your registry does not collect this SSF, use the description in the table to determine grade. If you collect this SSF, the information could be automatically converted into the grade field if it is coded 010-200. The grading system of the French Federation of Cancer Centers Sarcoma Group (FNCLCC) is the preferred system.

Record the grade from any three-grade sarcoma grading system the pathologist uses. For terms such as "well differentiated" or "poorly differentiated," go to Coding for Solid Tumors #8.

In some cases, especially for needle biopsies, grade may be specified only as "low grade" or "high grade." The numeric grade takes precedence over “low grade” or “high grade.”

Description	CS Code	Grade Code
Specified as Grade 1 [of 3]	010	2
Specified as Grade 2 [of 3]	020	3
Specified as Grade 3 [of 3]	030	4
Grade stated as low grade, NOS	100	2
Grade stated as high grade, NOS	200	4

Prostate (site: prostate excluding lymphomas; CS schema: prostate)

Use the highest Gleason score from the biopsy/TURP or prostatectomy/autopsy. Use a known value over an unknown value. Exclude results from tests performed after neoadjuvant therapy began. This information is collected in CSv2 SSF 8 (Gleason score from biopsy/TURP) and SSF 10 (Gleason score from prostatectomy/autopsy) as stated below. Use the table below to determine grade even if your registry does not collect these SSFs. If you collect these SSFs, the information could be converted into the grade field automatically.

Usually prostate cancers are graded using Gleason score or pattern. Gleason grading for prostate primaries is based on a 5-component system (5 histologic patterns). Prostatic cancer generally shows two main histologic patterns. The primary pattern, the pattern occupying greater than 50% of the cancer, is usually indicated by the first number of the Gleason grade, and the secondary pattern is usually indicated by the second number. These two numbers are added together to create a pattern score, ranging from 2 to 10. If there are two numbers, assume that they refer to two patterns (the first number being the primary pattern and the second number the secondary pattern), and sum them to obtain the score. If only one number is given on a particular test and it is less than or equal to 5 and not specified as a score, do not use the information because it could refer to either a score or a grade. If only one number is given and it is greater than 5, assume that it is a score and use it. If the pathology report specifies a specific

number out of a total of 10, the first number given is the score. Example: The pathology report says Gleason 3/10. The Gleason score would be 3.

Historic Perspective

Gleason Score	CS Code	Grade Code	AJCC 7th	SEER 2003-2013	AJCC 6th	SEER prior 2003
2	002	1	G1	G1	G1	G1
3	003	1	G1	G1	G1	G1
4	004	1	G1	G1	G1	G1
5	005	1	G1	G2	G2	G2
6	006	1	G1	G2	G2	G2
7	007	2	G2	G3	G3	G2
8	008	3	G3	G3	G3	G3
9	009	3	G3	G3	G3	G3
10	010	3	G3	G3	G3	G3

Historical perspective on long term trends in prostate grade: The relationship of Gleason score to grade changed for 1/1/2014+ diagnoses in order to have the grade field in sync with AJCC 7th ed. Analysis of prostate grade before 2014 based solely on the grade field is not recommended. In Collaborative Stage (CS), Gleason score was originally coded in CSv1 in one field (SSF 6) and then it was split into two fields in CSv2 based on the tissue used for the test: needle biopsy/TURP (SSF 8) and prostatectomy/autopsy (SSF 10). For trends using data back to 2004, if one collected the various CS Gleason scores, one could design a recode to have the same criteria as the data collected 2014+. The original grade field would NOT be changed, but for analyses this recode could be based on the CS SSFs and the original grade code.

CODING INSTRUCTIONS PRIOR TO 2014

Grade, Differentiation (Codes 1, 2, 3, 4, 9) - for solid tumors

Pathologic testing determines the grade, or degree of differentiation, of the tumor. For cancers, the grade is a measurement of how closely the tumor cells resemble the parent tissue (organ of origin). Well differentiated tumor cells closely resemble the tissue from the organ of origin. Poorly differentiated and undifferentiated tumor cells are disorganized and abnormal looking; they bear little or no resemblance to the tissue from the organ of origin.

Pathologists describe the tumor grade by levels of similarity. Pathologists may define the tumor by describing two levels of similarity (two-grade system which may be used for colon); by describing three levels of similarity (three-grade system); or by describing four levels of similarity (four-grade system). The four-grade system describes the tumor as grade I, grade II, grade III, and grade IV (also called well differentiated, moderately differentiated, poorly differentiated, and undifferentiated/anaplastic). These similarities/differences may be based on pattern (architecture), cytology, or nuclear features or a combination of these elements depending

upon the grading system that is used. The information from this data item is useful for determining prognosis.

Cell Indicator (Codes 5, 6, 7, 8, 9) - for hematopoietic and lymphoid malignancies

Cell indicator codes describe the lineage or phenotype of the cell that became malignant. If marker studies are not documented in the record, then code information on cell type from any source (i.e., history & physical). These codes apply to lymphomas and leukemias. Cell indicator codes take precedence over grade/differentiation codes for lymphoma and leukemia cases. **Do not** use "high grade," "low grade," or "intermediate grade" descriptions of lymphomas as a basis for differentiation. These terms are categories in the Working Formulation of Lymphoma Diagnoses and do not relate to grade/differentiation. For all hematopoietic and lymphoma cases diagnosed January 1, 2010 forward, use the guidelines in *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* to code grade. For cases diagnosed prior to that date, see the ICD-O-3 chapter Morphology for further instructions on coding grade.

Codes

Code	Grade/Cell	Label
1	Grade I, 1, i	Well differentiated; differentiated, NOS
2	Grade II, 2, ii I/III or 1/3	Moderately differentiated; moderately well differentiated; intermediate differentiation
3	Grade III, 3, iii II/III or 2/3	Poorly differentiated; dedifferentiated
4	Grade IV, 4, iv III/III or 3/3	Undifferentiated; anaplastic
For Lymphomas and Leukemias		
5		T cell; T-precursor
6		B cell; pre-B; B-percursor
7		Null cell; non T- non B
8		NK (natural killer) cell (effective with diagnosis 1/1/95 and after)
For Use in All Histologies		
9		Cell type not determined, not stated or not applicable; unknown primary; high grade dysplasia

General Coding Instructions

- The site specific coding guidelines in Appendix C of the SEER Program Coding and Staging Manual include instructions for coding grade for the following primary

sites/histologies: colon, breast, prostate, kidney, renal pelvis, ureter, bladder, urethra, astrocytoma, and sarcoma. Site-specific instructions take priority over general instructions.

- Code the grade or differentiation as stated in the **final** pathologic diagnosis. If grade is not stated in the final pathologic diagnosis, use the information from the microscopic description or comments.
- Record the tumor grade from the pathology report **prior** to neoadjuvant treatment. If there is no pathology report prior to neoadjuvant treatment, assign code 9.
- Code the grade from the primary tumor only, never from a metastatic site or a recurrence. Code to 9 when the primary site is unknown.
- If more than one grade is recorded for a single tumor, code the highest grade, even if it is a focus.
- Differentiation has priority over nuclear grade when both are specified. (*Example*: Liver biopsy histology described as "well differentiated hepatocellular carcinoma, nuclear grade 2/4." Code the tumor grade as grade 1.)
- Code the grade for in situ lesions if it is available. Code the grade of the invasive component when the tumor has both in situ and invasive portions. If the grade of the invasive component is unknown, code tumor grade as 9.
- Do not code the grade assigned to dysplasia (*Example*: High grade dysplasia (adenocarcinoma in situ). Code to 9 (unknown).)
- Code the grade of tumor given on a CT scan, MRI, or PET report only if there is no tissue diagnosis
- Do not use WHO grade to code this data item
- Some terms in ICD-O-3 carry an implied statement of grade. These histologies **must** be reported with the correct grade as stated below even if another grade is given or the primary site is unknown (C80.9):

  8020/34 Carcinoma, undifferentiated
  8021/34 Carcinoma, anaplastic
  8331/31 Follicular adenocarcinoma, well differentiated
  8851/31 Liposarcoma, well differentiated
  9062/34 Seminoma, anaplastic
  9082/34 Malignant teratoma, undifferentiated
  9083/32 Malignant teratoma, intermediate type
  9401/34 Astrocytoma, anaplastic
  9451/34 Oligodendroglioma, anaplastic
  9511/31 Retinoblastoma, differentiated
  9512/34 Retinoblastoma, undifferentiated

Terminology Conversion Table

Description	Grade	SEER Code
Differentiated, NOS	I	1
Well differentiated	I	1

Fairly well differentiated	II	2
Intermediate differentiation	II	2
Low grade	I-II	2
Mid differentiated	II	2
Moderately differentiated	II	2
Moderately well differentiated	II	2
Partially differentiated	II	2
Partially well differentiated	I-II	2
Relatively or generally well differentiated	II	2
Medium grade, intermediate grade	II-III	3
Moderately poorly differentiated	III	3
Moderately undifferentiated	III	3
Poorly differentiated	III	3
Relatively poorly differentiated	III	3
Relatively undifferentiated	III	3
Slightly differentiated	III	3
Dedifferentiated	III	3
High grade	III-IV	4
Undifferentiated, anaplastic, not differentiated	IV	4
Non-high grade		9

- Two-Grade System

Two grade systems apply to colon, rectosigmoid junction, rectum (C18.0-C20.9), and heart (C38.0). Code these sites using a two-grade system- Low Grade (2) or High Grade (4). If the grade is listed as 1/2 or as Low Grade, use code 2. If the grade is listed as 2/2 or as High Grade, use code 4.

Code	Terminology	Histologic Grade
2	Low grade	1/2

4	High grade	2/2

-Three-Grade System
There are several sites for which a three-grade system is used: peritoneum, endometrium, fallopian tubes, bladder, brain and spinal cord, and soft tissue sarcoma. For these sites, code the tumor grade using the following priority order: (1) terminology, (2) histologic grade, and (3) nuclear grade as show in the table below. The patterns of cell growth are measured on a scale of 1, 2, and 3 (also referred to as low, medium, and high grade). This system measures the proportion of cancer cells that are growing and making new cells and how closely they resemble the cells of the host tissue. Thus, it is similar to a four-grade system, but simply divides the spectrum into three rather than four categories (see comparison table below). The expected outcome is more favorable for lower grades. If the grade is written as 2/3, that means this is a grade 2 of a 3 grade system; do not simply code the numerator. Use the following table to convert the grade to the correct code.

CODE	TERMINOLOGY
2	Low grade, well to moderately differentiated; I/III or 1/3
3	Medium grade, intermediate grade, moderately undifferentiated, relatively undifferentiated; II/III or 2/3
4	High grade; poorly differentiated to undifferentiated; III/III or 3/3

Refer to the following instructions for breast, kidney, prostate, and CNS tumors.

-Breast (C50.0-C50.9)
For breast cancers, code the tumor grade using the following priority order: 1) Bloom-Richardson (Nottingham) Scores 3-9; 2) Bloom-Richardson Grade (low, intermediate, high); 3) Nuclear Grade only; 4) Terminology; and 5) Differentiation (well differentiated, moderately differentiated, etc.); 6) Histologic Grade.

BLOOM-RICHARDSON GRADING FOR BREAST CANCER

Synonyms for this grading system include modified Bloom-Richardson, Scarff-Bloom-Richardson, SBR grading, BR grading, Elston-Ellis and Nottingham modification of Bloom-Richardson grading. The Bloom-Richardson grading scheme is based on numeric scores assigned to three different morphologic features of invasive, no-special-type breast cancers (degree of tubule formation/histologic grade, mitotic activity, and nuclear pleomorphism of tumor cells). Use the table below to convert BR score, grade, or terminology:

BR Scores	BR Grade	Nuclear Grade	Terminology	Histologic Grade	Code

3-5	Low	1/3; 1/2	Well differentiated	I, I/III, 1/3	1
6, 7	Intermediate	2/3	Moderately differentiated	II, II/III, 2/3	2
8, 9	High	2/2; 3/3	Poorly differentiated	III, III/III, 3/3	3
---	---	4/4	Undifferentiated/anaplastic	IV, IV/IV, 4/4	4

Ductal carcinoma in situ (DCIS) is not always graded. When DCIS is graded, it is genearlly divided into three grades: low grade, intermediate grade, and high grade. Use the following table to convert DCIS grade in the SEER code.

DCIS Grade	Terminology	SEER Code
Grade I	Low	1
Grade II	Intermediate	2
Grade III	High	3

-Kidney (C64.9)
For kidney cancers, code the tumor grade using the following priority rules: 1) Fuhrman Grade; 2) Nuclear Grade; 3) Terminology (well diff, mod. diff); 4) Histologic Grade. These prioritization rules do not apply to Wilms tumor (M-8960).

-Prostate (C61.9)
For prostate cancers, code the tumor grade using the following priority order: 1) Gleason Score (this is the sum of the patterns, e.g., if the pattern is 2-4, the score is 6); 2) Terminology; 3) Histologic Grade; and 4) Nuclear Grade.

Gleason's Pattern
Prostate cancers are commonly graded using Gleason's score or pattern. Gleason's grading is based on a 5-component system, meaning it is based on 5 histologic patterns. The pathologist will evaluate the primary (majority) and secondary patterns for the tumor. The pattern is written as a range, with the majority pattern appearing first and the secondary pattern as the last number.

Gleason's Score
The patterns are added together to create a score. If the pathology report contains only **one number**, and that number is **less than or equal to 5**, it is a pattern. If the pathology report contains only **one number**, and that number is **greater than 5**, it is a score. If the pathology report specifies a specific **number out of a total of 10**, the first number given

is the score. If there are **two numbers other than 10**, assume they refer to two patterns. The first number is the primary pattern and the second is the secondary pattern. Use the following table to convert Gleason's pattern or score into SEER codes:

Gleason Conversion Table

Code	Gleason's Score (sum of primary and secondary patterns)	Terminology	Histologic Grade
1	2, 3, 4	Well differentiated	I
2	5, 6	Moderately differentiated	II
3	7, 8, 9, 10	Poorly differentiated	III

- CNS Tumors

- Grade astrocytomas (M-9383, 9400, 9401, 9410-9412, 9420, 9421) according to ICD-O-3 rules: I (well differentiated), Code 1; II (intermediate differentiation), Code 2; III (poorly differentiated), Code 3; IV (anaplastic), Code 4.
- Do not automatically code glioblastoma multiforme as Grade IV. If no grade is given, code 9 (unknown).
- For primary tumors of the brain and spinal cord (C71.0-C72.9) **do not** record the WHO grade in the field *Grade/Differentiation;* record the WHO grade in the data item *CS Site-Specific Factor 1*.
- All benign and borderline intracranial tumors should be coded grade 9.

30131 - Grade Path Value

Field Length: 1

***** This data item was discontinued effective 01/01/2014*****

This field documents the numerator or first number of a tumor grade reported in a 2, 3, or 4 grade system. It is paired with Grade Path System (item #30132) to describe the original grade of the tumor. It may be left blank for cases diagnosed prior to January 1, 2010.

Instructions for Coding

- Code this item from the same tissue as that used to code Tumor Grade (item #30130)
- Code the histologic grade in priority over a nuclear or architectural grade.
- Do not convert the terms *well*, *moderately*, or *poorly differentiated*, *low/high*, or *anaplastic* into codes in this field. Leave blank if those terms are the only available grade information.
- If grade is described in the medical record as a fraction (x/y), this field is the numerator. In other words, this field is the first or upper number of a grade expressed in two parts
- Leave this item blank if another grading system is used in the pathology report. For example, do not report grading systems such as Bloom-Richardson for breast primaries, Fuhrman for kidney, Gleason for prostate, or WHO grade. Those grading systems are coded in a site-specific factor for the applicable CS schema.
- Leave this item blank for lymphomas and hematopoietic malignancies (9590-9992)
- This item and Grade Path System (item #30132) should both be coded or both be blank. If both are coded, Tumor Grade (item #30130) must not be 9. Grade Path Value can never be larger than Grade Path System.

Code	Description
blank	No 2-, 3- or 4-grade system available. Unknown.
1	Recorded as Grade I or 1
2	Recorded as Grade II or 2
3	Recorded as Grade III or 3
4	Recorded as Grave IV or 4

Examples

Code	Reason
1	The pathology report indicates the grade is 1/4
2	Synoptic report says grade ii of iii

3	Microscopic description reports high grade III of III
blank	No mention of grade in the pathology report

30132 - Grade Path System

Field Length: 1

***** This data item was discontinued effective 01/01/2014*****

This field documents the denominator or second number of a tumor grade reported in a 2, 3, or 4 grade system. This item is used in conjunction with Grade Path Value (item #30131) to describe the original grade of the tumor. It may be left blank for cases diagnosed prior to January 1, 2010

Instructions for Coding

- Code this item from the same tissue as that used to code Tumor Grade (item #30130)
- If grade is described in the medical record as a fraction (x/y), this field is the denominator. In other words, this field is the second or lower number of a grade expressed in two parts.
- Leave this item blank if no pathologic grade is available
- Leave this item blank if only a verbal description of grade is reported (i.e., moderately differentiated)
- Leave this item blank if another grading system is used in the pathology report. For example, do not report grading systems such as Bloom-Richardson for breast primaries, Fuhrman for kidney, Gleason for prostate, or WHO grade. Those grading systems are coded in a site-specific factor for the applicable CS schema.
- Leave this item blank for lymphomas and hematopoietic malignancies (9590-9992)
- This item and Grade Path Value (item #30131) should both be coded or both be blank. If both are coded, Tumor Grade (item #30130) must not be 9.

Code	Description
blank	No 2, 3, or 4 grade system was used. Unknown.
2	Recorded as Grade II or 2
3	Recorded as Grade III or 3
4	Recorded as Grade IV or 4

Examples

Code	Reason
4	The final pathologic diagnosis indicates that the grade is 1/4

3	Synoptic report says grade ii of iii
3	Microscopic description reports high grade III of III
blank	No mention of grade in the pathology report

30135 - LYMPH-VASCULAR INVASION

Field Length: 1

This field indicates the presence or absence of tumor cells in lymphatic channels (NOT lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist. It is a mandatory field for cases diagnosed January 1, 2010 onward.

Note: This data item is separate from the CS data items but is included in this manual because of its relationship to the Collaborative Stage Data Collection System. Lymph-vascular invasion is an item of interest to both pathologists and clinicians and is mentioned in many chapters of the AJCC Cancer Staging Manual, seventh edition.

Note: This field is *required* for mapping of T in some sites, such as testis and penis.

Instructions for Coding

- This item may be left blank for cases diagnosed before 2010.
- The primary source of this information is the College of American Pathologists (CAP) synoptic report or checklist. If it is unavailable, code from the pathology report or a physician's statement, in that order of priority.
- Use code 1 if lymph-vascular invasion is identified anywhere in a primary tumor specimen.
- Use code 8 for histologies 9590-9992.
- Use code 9 if no pathologic examination of primary site tissue was performed.
- Use code 9 if primary site tissue was examined pathologically, but the report is not available.
- Use code 9 if the pathology report indicates that the presence of lymph-vascular invasion could not be determined.

Code	Description
0	Lymph-vascular invasion is not present (absent) or is not identified
1	Lymph-vascular invasion is present or identified
8	Not applicable
9	Unknown or indeterminate

Definition

Lymph-vascular invasion is defined as the presence of tumor cells found inside small blood vessels or lymphatic channels within the tumor and surrounding tissues in the primary site. The tumor cells have broken free of the primary tumor and now have the capability to float throughout the body. Other names for lymph-vascular invasion are LVI, lymphovascular invasion, vascular invasion, blood vessel invasion, and lymphatic invasion. Vascular invasion is not the same as direct tumor extension from the primary tumor into adjacent blood vessels; LVI cells are not attached to or growing into the wall of the blood vessel. Lymphatic invasion is not the same as involvement of regional lymph nodes. Lymph-vascular invasion does not include perineural invasion.

Instructions for Coding

1. **Code from pathology report(s)**. Code the absence or presence of lymph-vascular invasion as described in the medical record.
    a. The primary sources of information about lymph-vascular invasion are the pathology check lists (synoptic reports) developed by the College of American Pathologists. If the case does not have a checklist or synoptic report, code from the pathology report or a physician's statement, in that order.
    b. Do not code perineural invasion in this field.
    c. Information to code this field can be taken from any specimen from the primary tumor (biopsy or resection.)
    d. If lymph-vascular invasion is identified in any specimen, it should be coded as present/identified.
    e. For cases with benign or borderline behavior, code the lymph-vascular invasion documented (negative or positive) and, if not documented, code unknown.
    f. For cases treated with neoadjuvant therapy, refer to table below in order to code this field. However, if documentation in the medical record indicates information that conflicts with this table, code lymph-vascular invasion with the documentation in the medical record.

LVI on pathology report PRIOR to neoadjuvant therapy	**LVI on pathology report AFTER neoadjuvant therapy**	***Code LVI to:***
0 - Not present/Not identified	0 - Not present/Not identified	*0 - Not present/Not identified*
0 - Not present/Not identified	1 - Present/Identified	*1 - Present/Identified*
0 - Not present/Not identified	9 - Unknown/Indeterminate	*9 - Unknown/Indeterminate*

1 - Present/Identified	0 - Not present/Not identified	*1 - Present/Identified*
1 - Present/Identified	1 - Present/Identified	*1 - Present/Identified*
1 - Present/Identified	9 - Unknown/Indeterminate	*1 - Present/Identified*
9 - Unknown/Indeterminate	0 - Not present/Not identified	*9 - Unknown/Indeterminate*
9 - Unknown/Indeterminate	1 - Present/Identified	*1 - Present/Identified*
9 - Unknown/Indeterminate	9 - Unknown/Indeterminate	*9 - Unknown/Indeterminate*

2. **Use of codes.**
    a. Use code 0 when the pathology report indicates that there is no lymph-vascular invasion. This includes cases of purely in situ carcinoma, which biologically have no access to lymphatic or vascular channels below the basement9 - Unknown/Indeterminate membrane.
    b. **Use code 1 when the pathology report or a physician's statement indicates that lymph-vascular invasion (or one of its synonyms) is present in the specimen.**
    c. **Use code 8 for the following primary sites.**

        Hodgkin and Non-Hodgkin lymphoma

        Leukemias

        Hematopoietic and reticuloendothelial disorders

        Myelodysplastic syndromes including refractory anemias and refractory cytopenias

        Myeloproliferative disorders

    d. Use code 9 when
        i. there is no microscopic examination of a primary tissue specimen
        ii. the primary site specimen is cytology only or a fine needle aspiration
        iii. the biopsy is only a very small tissue sample
        iv. it is not possible to determine whether lymph-vascular invasion is present
        v. the pathologist indicates the specimen is insufficient to determine lymph-vascular invasion
        vi. lymph-vascular invasion is not mentioned in the pathology report
        vii. primary site is unknown
    e. Clarification between codes 8 and 9:

        i. Code 8 should only be used in the following situations: 1. Standard-setter does not require this item and you are not collecting it. 2. Those histologies noted above described in code 8 for which LVI is always not applicable.

ii. For those cases where there is no information/documentation from the pathology report or other sources, use code 9

30140 - CLASS OF CASE

Field Length: 2

Class of case reflects the facility's role in managing this cancer, whether the cancer is required to be reported to ACoS by approved facilities, and whether the case was diagnosed after the program's reference date. Enter the two digit code that describes the patient's relationship to the facility.

Instructions for Coding

- Code 00 applies only when it is known that the patient went elsewhere for treatment. If that information is not available, code class of case '10.' It is possible that information for coding class of case will change during the patient's first course of care. If that occurs, edit the code accordingly.
- ACoS approved facilities should document Institution Referred To (item #31660) for patients coded 00 to establish that the patient went elsewhere for treatment.
- A staff physician (codes 10-12, 41) is a physician who is employed by the reporting facility, under contract with it, or who has routine practice privileges there.
- Refer to the "Case Reporting Requirements" section of this manual for a discussion of Classes and KCR requirements.

Codes

Analytic Classes of Case (Required by CoC to be abstracted by accredited programs)	
Code	Description
	Initial diagnosis at reporting facility
00	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
10	Initial diagnosis at the reporting facility or in a staff physician's office AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS
11	Initial diagnosis in staff physician's office AND part of first course treatment was done at the reporting facility
12	Initial diagnosis in staff physician's office AND all first course treatment or decision not to treat was done at the reporting facility
13	Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility
14	Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility
	Initial diagnosis elsewhere

20	Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS
21	Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility
22	Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility
Non-analytic Classes of Case (Not required by CoC to be abstracted by accredited programs, but may be required by KCR)	
	Patient appears in person at reporting facility
30	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (i.e., consult only or staging workup)
31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care
32	Diagnosis AND all first course treatment provided elsewhere AND patients presents at reporting facility with disease recurrence or persistence
33	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only
34	Type of case not required by CoC to be accessioned (i.e., CIS of the cervix) AND initial diagnosis AND part or all of first course treatment by reporting facility
35	Case diagnosed before program's reference date AND initial diagnosis AND all or part of first course treatment by reporting facility
36	Type of case not required by CoC to be accessioned (i.e., CIS of the cervix) AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility
37	Case diagnosed before program's reference date AND initial diagnosis elsewhere AND all or part of first course treatment by facility
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death
	Patient does not appear in person at reporting facility **Do not abstract cases in class 40 - 99- refer them to KCR; these classes are for KCR use only**
40	Diagnosis AND all first course treatment given at the same staff physician's office
41	Diagnosis and all first course treatment given in two or more different staff physician offices
42	Nonstaff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (i.e., hospital abstracts cases from an independent radiation facility)
43	Pathology or other lab specimens only
49	Death certificate only

98	Non-hospital treatment abstracted by KCR
99	Non-hospital cases abstracted by KCR

30145 - Place of Diagnosis

Field Length: 60

This item is an optional text field for documentation of the facility, physician office, city, state, or county where the intial diagnosis was made. Text documentation is an essential component of a complete abstract and is heavily utilized for quality control and special studies.

If the patient was diagnosed with this cancer in Kentucky, be as specific as possible. Use this field to indicate the facility, physician's office, or location where the diagnosis was made. If the patient was diagnosed outside Kentucky, be as specific as possible, even though the city, state, or country of residence may be the best available information.

30150 - DATE OF FIRST CONTACT

Field Length: 8

The date of first contact is the date of the facility's first inpatient or outpatient contact with the patient for diagnosis or treatment of the cancer. In most instances, it is the patient's physical presence at the facility that denotes "contact." When a pathology specimen is collected off-site and submitted to the facility to be read (and the specimen is positive for cancer), but the patient is never seen at the facility, the case is not required to be abstracted (although a copy of the pathology report must be sent to KCR to be abstracted).

Instructions for Coding

- Record the date the patient first had contact with the facility as either an inpatient or outpatient for the diagnosis and/or treatment of a reportable tumor. The date may be the date of an outpatient visit for a biopsy, X-ray, or laboratory test, or the date a pathology specimen was collected at the hospital.
- If this is an autopsy or death certificate only case, then use the date of death.
- When a patient is diagnosed in a staff physician's office, the date of first contact is the date the patient was physically first seen at the reporting facility.

Examples

A patient has an outpatient mammography that is suspicious for malignancy on February 12, 2008, and subsequently undergoes an excisional biopsy or radical surgical procedure on February 14, 2008	02/12/2008
Patient undergoes a biopsy in a physician's office on September 8, 2009. The pathology specimen is sent to the reporting facility and read as malignant melanoma. The patient enters the reporting facility on September 14, 2009 for wide re-excision.	09/14/2009
Patient has an MRI of the brain on December 7, 2010, for symptoms including severe headache and disorientation. The MRI findings are suspicious for astrocytoma. Surgery on December 19 removes all gross tumor.	12/07/2010

30160 - DATE OF DIAGNOSIS

Field Length: 8

Enter the month, day, and year of the initial diagnosis.

This field refers to the date of first diagnosis of this cancer by a recognized medical practitioner. This is the date of the first clinical diagnosis, and in some cases, the diagnosis may never be histologically confirmed. Do not change the date of diagnosis when a later biopsy or cytology provides confirmation of a clinical diagnosis. From 2009 forward, for cases which are diagnosed *in utero*, record the actual date of diagnosis. For pre-2009 cases, the date of diagnosis for *in utero* cases should be the date of birth.

Code the date using a zero to precede single digit days, or months, i.e., June is entered as 06.

If the exact date is not known, record the best approximation on the basis of available information. As possible guidelines, consider the following:

a. For patients diagnosed without positive tissue while in a hospital, the date of admission may be used as the best estimate of the date of diagnosis.

b. For patients diagnosed before entering the hospital (i.e., clinic or physician's office), the date of first admission may be used if it seems that the patient was hospitalized within three months or less from the true date of diagnosis by the referring physician.

c. If the only information is "Spring of", "Middle of the year", or "Fall", approximate these as April 1st, July 1st, or October 1st, respectively.

The date of death is the date of diagnosis for a class of case 38.

30170 - AGE AT DIAGNOSIS

Field Length: 3

This field is calculated by the computer for the primary malignancy that is being abstracted. It is the number of years between the date of birth and the date of diagnosis.

30180 - Medical Record Number

Field Length: 11

Enter the medical record number assigned by the health information management (HIM) department. Dashes or special characters may be entered in this field; however, they should be used consistently.

30190 - Family History of this Cancer

Field Length: 1

Record the appropriate code to indicate if any of the patient's primary family members (i.e., parent, grandparent, child, sibling, aunt or uncle) had or has this type of cancer. "This type of cancer" means any diagnosis in the same site group as this patient's.

Code	Description
1	Yes, there is a family history of this cancer
2	No, there is no recorded family history of this cancer
9	Unknown if there is a family history of this cancer

30200 - MARITAL STATUS AT DIAGNOSIS

Field Length: 1

Record the one digit code specifying the patient’s marital status at the time of diagnosis for this tumor, if known.

Code	Description
1	Single (never married)
2	Married (including common law)
3	Separated
4	Divorced
5	Widowed
6	Unmarried or domestic partner (same sex or opposite sex, registered or unregistered) (effective for cases diagnosed 1/1/2011 forward)
9	Unknown

Persons of the opposite sex living together as part of a long term personal relationship would be coded to ’2' - Married, including common law.

30210 - Menopausal Status

Field Length: 1

Record the menopausal status if this is a female patient.

Code	Description
0	Pre menopausal (include perimenopausal patients in code 0)
1	Post menopausal, (even if surgically or chemically induced)
9	Unknown/ not applicable

Assume women over the age of 60 or those undergoing a hysterectomy prior to age 60 as post menopausal, even if it is not specifically stated in the medical chart. For male patients, this field will automatically be coded '9'.

30220 - PRIMARY PAYER

Field Length: 2

Code the patient's primary payer or insurance carrier at the time of initial admission.

Code	Label	Description
01	Not insured	Patient has no insurance and is declared a charity write-off
02	Not insured, self pay	Patient has no insurance and is declared responsible for charges
10	Insurance, NOS	Type of insurance unknown or other than the types listed in codes 20, 31, 35, 50-56
20	Managed Care, HMO, PPO	An organized system of prepaid care for a group of enrollees usually within a defined geographic area
21	Private Insurance: Fee-for-service	An insurance plan that does not have a negotiated fee structure with the participating hospital
31	Medicaid	State government administered insurance for persons who are uninsured, below the poverty level, or covered under entitlement programs
35	Medicaid administered through a Managed Care Plan	State government administered insurance which is administered through a commercial Managed Care plan
60	Medicare without supplement, Medicare, NOS	Federal government funded insurance for persons who are retired or disabled, or over 65 years old
61	Medicare with supplement	Patient has Medicare and another insurance to pay costs not covered by Medicare
62	Medicare administered through a Managed Care Plan	Patient enrolled in Medicare through a Managed Care Plan (e.g. HMO, PPO). The plan pays for all incurred costs
63	Medicare with private supplement	Patient has Medicare and private insurance to pay costs not covered by Medicare
64	Medicare with Medicaid eligibility	Federal government Medicare insurance with State Medicaid administered supplement
65	TRICARE (Formerly CHAMPUS)	Department of Defense program providing supplementary civilian-sector hospital and medical services to military dependents, retirees, and their dependents

66	Military	Military personnel or their dependents who are treated at a military facility
67	Veterans Affairs	Veterans who are treated in Veterans Affairs facilities
68	Indian/Public Health Service	Patient who receives care at an Indian Health Service facility and costs are reimbursed by the Indian Health Service.
99	Insurance status unknown	It is unknown from the patient's medical record whether or not the patient is insured

30230 - ACOS SEQUENCE NUMBER

Field Length: 2

The ACoS sequence number represents the order of all primary reportable tumors diagnosed during a patient's lifetime. It counts the occurrence of independent, malignant primaries that are required to be reported to the ACoS for approved cancer programs.

The sequence number 00 indicates that this patient has one primary cancer. The sequence 01 indicates that the case is the first of multiple primaries.

Sequence numbers in the range of 60-88 have a special meaning to ACoS. They are reserved for conditions that are collected by the registry but are not required by ACoS. These include diagnoses required by KCR but not ACoS (such as VIN III, VAIN III, and AIN III, as well as invasive recurrences abstracted after an in-situ cancer.) Pre-invasive carcinomas of the cervix that were diagnosed in 1996 and 1997 will be sequenced in this range also, because they were required by KCR at the time, but not ACoS.

As of January 1, 2004, benign and borderline intracranial tumors became reportable to ACoS as well as KCR. These are sequenced in the 60-88 series.

Codes (conditions reportable to ACoS):

Code	Description
00	One primary only
01	First of two or more primaries
02	Second of two or more primaries
03	Third of three or more primaries
--	(Actual number of this primary)
35	Thirty fifth primary
60	First of non-ACoS reportable condition (i.e. VIN III, VAIN III, AIN III, CIN III, CIS of cervix) or benign intracranial tumor
61	Second of non-ACoS reportable condition
87	Twenty seventh non-ACoS reportable condition

This field will automatically be calculated by the computer based on the CPDMS sequence number for this case and the number and types of primaries stored for this patient.

30240 - SEER SEQUENCE NUMBER

Field Length: 2

The SEER sequence number represents the order of all primary reportable tumors diagnosed during a patient's lifetime. It counts the occurrence of independent, malignant primaries that are required to be reported to the SEER Program.

The sequence number 00 indicates that this patient has one primary cancer. The sequence 01 indicates that the case is the first of multiple primaries.

Sequence numbers in the range of 60-88 have a special meaning to SEER. They are reserved for conditions that are collected by the registry but are not required to be reported to SEER. These include all basal and squamous cell carcinomas of the skin diagnosed and reported before 2003 (C44._ with M8000-M8110) as well as all pre-invasive carcinomas of the cervix diagnosed in 1996 and 1997.

As of January 1, 2004, benign and borderline intracranial tumors became reportable to SEER as well as KCR. These are sequenced in the 60-88 series.

Codes (conditions reportable to SEER):

Code	Description
00	One primary only
01	First of two or more primaries
02	Second of two or more primaries
03	Third of three or more primaries
--	(Actual number of this primary)
35	Thirty fifth primary
60	First of non-ACoS reportable condition (i.e. VIN III, VAIN III, AIN III, CIN III, CIS of cervix) or benign intracranial tumor
61	Second of non-ACoS reportable condition
87	Twenty seventh non-ACoS reportable condition

This field will automatically be calculated by the computer based on the CPDMS sequence number for this case and the number and types of primaries stored for this patient.

30250 - ADDRESS AT DIAGNOSIS - LINE 1

Field Length: 40

This field is automatically filled in with the address entered in Item 10060 (Current Address) when the case is initially entered in CPDMS.net Note that if the patient has multiple tumors, the address may be different for subsequent primaries.

This address is a part of the patient's case data and has multiple uses. It is used in geocoding and allows referral pattern reports and analysis of cancer clusters or environmental studies. These data may be corrected (if erroneous), but **never** update the address at diagnosis if the patient moves. Changing this field would destroy its usefulness. If it is necessary to edit this field, follow the street address guidelines in Item 10060.

30260 - ADDRESS AT DIAGNOSIS - LINE 2

Field Length: 40

This field is automatically filled in with the data in Item 10070 (Current Street Address- Line 2) when the case is initially entered into CPDMS.net. It provides space to record additional address information, such as the name of a nursing home, apartment complex, etc. This line will be used as an alternate address line for geocoding. If Address at Diagnosis-Line 1 cannot be geocoded (i.e. PO Box), then this line will be reviewed for a geocode. Do not update this item if the patient's address changes. Leave this field blank if the additional address space is not needed.

30270 - ADDRESS AT DIAGNOSIS - CITY

Field Length: 20

This field is automatically filled in with the data entered in Item 10080 (Current Address - City) when the case is initially entered into CPDMS.net Note that if the patient has multiple tumors, the address may be different for subsequent primaries. A list of Kentucky cities and towns is located in Appendix D.

The address is a part of the patient's case data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies. These data may be corrected, but **never** update the address at diagnosis if the patient moves. Changing this field would destroy its usefulness.

30280 - ADDRESS AT DIAGNOSIS - STATE

Field Length: 2

This field is automatically filled in with the state entered in Item 10090 (Current Address - State) when the case is initially entered into CPDMS.net. Note that if the patient has multiple tumors, the address may be different for subsequent primaries.

If the address at diagnosis is not the same as the current address, then enter the correct address at diagnosis here. The address at diagnosis is a part of the patient's case data and has multiple uses. This field is critical for cancer incidence reporting. It will allow the state registry to exchange cases with contiguous states. It will also allow analysis of cancer clusters or environmental studies. This data may be corrected, but **never** update the address at diagnosis if the patient moves.

See APPENDIX B to code this field.

Examples:

Code	Definition
KY	If the state in which the patient resides at the time of diagnosis and treatment is Kentucky, then use the USPS code for the state of Kentucky.
XX	Resident of a country of than the U.S. (including it territories, commonwealths, or possessions) or Canada and the country is *known*.
YY	Resident of a country other than the U.S. (including it territories, commonwealths, or possessions) or Canada and the country is *unknown*.
US	Resident of the U.S. (including it territories, commonwealths, or possessions) and the state is *unknown*.
CD	Resident of Canada and the province is *unknown*.
ZZ	Residence unknown.

30290 - 30300 - ADDRESS AT DIAGNOSIS - ZIP CODE

Field Length: 9

These fields are automatically filled in with the ZIP code entered in Items 10100-10110 (Current ZIP Code). Note that if the patient has multiple tumors, the ZIP code may be different for subsequent primaries.

The address is a part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies. This data may be corrected, but **never** update the address at diagnosis if the patient moves. Changing this field would destroy its usefulness. If it is necessary to edit this field, follow the ZIP code guidelines in Items 10100-10110.

30301 - ADDRESS AT DIAGNOSIS - COUNTRY

Field Length: 3

Record the three character abbreviation for the country of the patient’s residence at the time of diagnosis. This item corresponds to Address at DX items (state, postal code). See APPENDIX B.

Common Country Codes

Code	Description
USA	United States
CAN	Canada
ZZX	Not US or Canada, but no other information
ZZU	Unknown

30310 - ADDRESS AT DIAGNOSIS - COUNTY

Field Length: 5

This field represents the patient's **county of residence at the time of diagnosis**. It is a five digit field where the first two digits represent the state of residence and the last three digits represent the county of residence in that state. The codes are taken from FIPS Publication Number 6-4, Counties and Equivalent Entities of the United States, its Possessions, and Associated Areas, as reissued July 7, 2001, and are made available electronically on the National Institute of Standards and Technology Web Site (http://www.itl.nist.gov/fipspubs/co-codes/states.htm). The state code for Kentucky is 21.

The county codes for Kentucky and its contiguous states are listed in Appendix D. CPDMS.net automatically calculates the correct county code from the address at diagnosis if the state is Kentucky and the ZIP code is within a single county. If a Kentucky ZIP code encompasses more than one county, the use must fill in this field. The U.S. Census Bureau web site has a helpful feature which displays the county (along with other information) of a particular address. The URL is http://factfinder.census.gov/servlet/AGSGeoAddressServlet?_lang=en&_programYear=50&_treeId=420.

Use Appendix D to code the state/county code for neighboring states.

Use code '00998' for any county outside Kentucky and its neighboring states.

Use code '00999' for unknown county of residence at diagnosis.

If the patient moves, do not change this code. It should remain the same as it was at the time this primary malignancy was diagnosed.

Note: This field is used to calculate the following geographic variables for Kentucky residents:

Area Development District
Appalachia (or non-Appalachia)
Beale Code (rural-urban continuum)

30320- 30330 - ACCESSION YEAR AND NUMBER

Field Length: 9

These fields are used to identify cases by year accessioned in the order in which they were entered into the registry at your institution. The first four digits should be the year the patient was first seen in your institution. The last five digits will be the next number available to be assigned, i.e., the first case accessioned in 1991 will be recorded 19910001.

Exceptions: A patient enters the reporting institution in December 2002 and is diagnosed with cancer in January 2003. The accession number is 2003 _ _ _ _.

The registry's reference date is January 1, 1996. A patient is diagnosed with breast cancer and has a partial mastectomy at the reporting institution in December 1995. The patient starts a course of radiation therapy at the reporting institution in January 1996. Assign the accession number
1996 _ _ _ _ .

30340 - Tumor Marker 1

Field Length: 1

For cases diagnosed on or after January 1, 2004, tumor markers are collected in the Collaborative Stage Site Specific Factors fields and not in this data field. For earlier diagnoses, this table lists the site/histology for which tumor marker 1 is collected.

SITE/HISTOLOGY	MARKER #1
Breast (C50.0-C50.9)	Estrogen Receptor Assay (ERA)
Colorectal (C18.0-18.9, C19.9, C20.9)	Carcinoembryonic Antigen (CEA)
Liver (C22.0, C22.1)	Alpha Fetoprotein (AFP)
Neuroblastoma (9500/3)	Urine catecholamine
Ovary (C56.9)	Carbohydrate Antigen 125 (CA-125)
Prostate (C61.9)	Acid Phosphatase (PAP)
Testis (C62.0, C62.1, C62.9)	Alpha Fetoprotein (AFP) Range 1 <1,000 ng/ml Range 2 1,000 - 10,000 ng/ml Range 3 > 10,000 ng/ml

Record the appropriate code as indicated below.

Code	Description
0	None done (test was not ordered and was not performed)
1	Positive/Elevated (breast and prostate only)
2	Negative/Normal
3	Borderline, undetermined whether positive or negative (breast and prostate only)
4	Range 1 (testis only, AFP, See Table)
5	Range 2 (testis only, AFP, See Table)
6	Range 3 (testis only, AFP, See Table)
8	Ordered, but results not in chart; or results not convertible to Range 1, 2, or 3
9	Unknown or no information (all sites other than those specified in the table)

Testicular Cancer
Acceptable codes for testicular cancer are 0, 2, 4, 5, 6, 8, and 9. For testis cases only, record alpha-fetoprotein (AFP) in Tumor Marker 1. If there are serial serum tumor markers, record the lowest (nadir) value of AFP after orchiectomy in the first course of treatment.

30350 - Tumor Marker 2

Field Length: 1

For cases diagnosed on or after January 1, 2004, tumor markers are collected in the Collaborative Stage Site Specific Factors fields and not in this data field. For earlier diagnoses, this table lists the sites for which tumor marker 2 is collected.

SITE	MARKER
Breast (C50.0-50.9)	Progesterone Receptor Assay (PRA)
Prostate (C61.9)	Prostatic Specific Antigen (PSA)
Testis (C62.0, C62.1, C62.9)	Human chorionic gonadotropin (hCG) Range 1 <5,000 mIU/ml Range 2 5,000 - 50,000 mIU/ml Range 3 >50,000 mIU/ml

Code	Description
0	None done (test was not ordered and was not performed)
1	Positive/Elevated (breast and prostate only)
2	Negative/Normal
3	Borderline, undetermined whether positive or negative (breast and prostate only)
4	Range 1 (testis only, AFP, See Table)
5	Range 2 (testis only, AFP, See Table)
6	Range 3 (testis only, AFP, See Table)
8	Ordered, but results not in chart; or results not convertible to Range 1, 2, or 3
9	Unknown or no information (all sites other than those specified in the table)

Testicular Cancer
Acceptable codes for testicular cancer are 0, 2, 4, 5, 6, 8, 9. For testis cases only, record the Human Chorionic Gonadotropin (hCG) in Tumor Marker 2. If there are serial serum tumor markers, record the lowest (nadir) value of hCG after orchiectomy in the first course of treatment.

30360 - Tumor Marker 3

Field Length: 1

For cases diagnosed on or after January 1, 2004, tumor markers are collected in the Collaborative Stage Site Specific Factors fields and not in this data field. For earlier diagnoses, "Tumor Marker Three" records prognostic indicators for testicular cancer only.

SITE/HISTOLOGY	MARKER #3
Testis (C62.0, C62.1, C62.9)	LDH Range 1 <1.5 x N* Range 2 1.5-10 x N* Range 3 >10 x N* * N equals the upper limit of normal for the LDH

Record the appropriate code as indicated below.

Code	Description
0	None done (test was not ordered and was not performed)
1	Positive/Elevated (breast and prostate only)
2	Negative/Normal
3	Borderline, undetermined whether positive or negative (breast and prostate only)
4	Range 1 (testis only, AFP, See Table)
5	Range 2 (testis only, AFP, See Table)
6	Range 3 (testis only, AFP, See Table)
8	Ordered, but results not in chart; or results not convertible to Range 1, 2, or 3
9	Unknown or no information (all sites other than those specified in the table)

30370- 30400 - Diagnostic and Staging Procedures

Field Length: 1 (x 4)

Specific diagnostic and staging procedures were defined for breast and prostate cancers only for diagnoses dates between 1/1/1998 and 12/31/2002. They are now optional fields and are no longer required to be coded.

If the primary site is other than breast or prostate, code all data items 0 or leave blank. If more than one code applies, use the highest code (excluding 9).

30370 - Biopsy Procedure (Breast Only)

These are biopsies that do not grossly remove the primary tumor and/or surgical margins were macroscopically involved.

> If the primary tumor was grossly removed during the biopsy procedure, code Biopsy Procedure and Guidance items 0 (not done, not a separate procedure). The biopsy would be coded as cancer-directed surgery.

Code	Description
0	Not done, not a separate procedure
1	Biopsy, NOS
2	Fine needle aspiration (cytology)
3	Core biopsy (histology)
5	Excision of major duct (if procedure removes all gross primary tumor, code as cancer-directed surgery)
9	Unknown if biopsy performed, death certificate only

30380 - Guidance (Breast Only)

Code	Description
0	Not guided, no biopsy of primary site
1	Guided, NOS
2	Radiographic NOS (no dye or dye unknown)
3	Mammographic; wire/needle localization
4	Stereotactic
5	Dye only

6	Dye plus (1-3)
7	Ultrasound
9	Unknown if guided; biopsy performed; death certificate only

30390 - Palpability of Primary (Breast Only)

Code	Description
0	Not palpable
1	Palpable
9	Palpability not stated; death certificate only

30400 - First Detected By (Breast Only)

Record the method by which the breast mass or abnormality was first recognized.

Code	Description
0	Not a breast or prostate primary
1	Patient first felt lump or noted nipple discharge
2	Physician first felt lump
3	Mammography - routine (screening)
4	Occult; incidental finding during other procedure
9	Unknown how first detected

30370 - Biopsy Procedure (Prostate Only)

Code	Description
0	Not done, not a separate procedure
1	Incisional biopsy, NOS
2	Fine needle aspiration (cytology)
3	Needle core biopsy; biopsy gun (histology)

4	6 cores or more of tissue from both lobes of the prostate
9	Unknown if biopsy of primary was done; death certificate only

30380 - Guidance (Prostate Only)

Code	Description
0	Not guided; no biopsy of primary
1	Guided, NOS
2	Radiographic
3	Ultrasound
9	Unknown if guided, biopsy performed; death certificate only

30390 - Approach for Biopsy of Primary (Prostate Only)

Code	Description
0	No biopsy
1	Transrectal
2	Transperineal
3	Transurethral
4	Laparoscopic
5	Open (laparotomy)
9	Unknown approach, but biopsy performed; death certificate only

30340 - Biopsy of Other than Primary (Prostate Only)

Code	Description
0	No biopsy of other than primary
1	Biopsy of seminal vesicle(s), NOS

2	Unilateral
3	Bilateral
4	Other than seminal vesicle
5	4 + 1
6	4 + 2
7	4 + 3
9	Unknown if biopsy of other than primary; death certificate only

30410 - LATERALITY

Field Length: 1

Enter the one digit code which describes this primary with regard to involvement of one or both sides of paired organs (see list below).

Code	Description
0	Not paired
1	Right origin
2	Left origin
3	Only one side involved, right or left origin unspecified
4	Bilateral, side of origin unknown or single primary (i.e. bilateral Wilms' tumors)
5	Midline origin
9	Paired, but no information concerning laterality

Coding Instructions

1. Use code 0 (not a paired organ) for an unknown primary site (C80.9).

2. Code laterality using codes 1-9 for all of the sites listed below. *Note*: Laterality may be coded for sites other than those listed below.

3. Code the side where the primary tumor originated.

   a. Assign **code 3** if the laterality is not known but the tumor is confined to a single side of the paired organ.

   Example: Pathology report: Patient has a 2cm carcinoma in the upper pole of the kidney. Code laterality as 3 because there is documentation that the disease exists in only one kidney, but it is unknown if the disease originated in the right or left kidney.

4. **Code 4** is seldom used EXCEPT for the following diseases:
   i. Both ovaries involved simultaneously, single histology
   ii. Bilateral retinoblastomas
   iii. Bilateral Wilms' tumor
   iv. If both lungs have nodules or tumors and the lung of origin is not known

5. Assign code 5 when the tumor originates in the midline of a site listed in 5.a.
    a. C700, C710 - C714, C722 - C725, C443, C445

    Example 1:Patient has an excision of a melanoma located just above the umbilicus.

    Example 2:Patient has a midline meningioma of the cerebral meninges.

6. Assign code 9 when:
    a. The neoplasm originated in a paired site and
        1. Laterality is unknown

        AND

        2. There is no statement that only one side of the paired organ is involved.

        Example 1: Admitting history says patient was diagnosed with lung cancer based on positive sputum cytology. Patient is treated for painful bony metastases. There is no information about laterality in the diagnosis of this lung cancer.

        Example 2: Widely metastatic ovarian carcinoma surgically debulked. Ovaries could not be identified in the specimen.

    b. Laterality is unknown for a death certificate only (DCO)case with primary site C079 - C081, C090-C091, C098-C099, C301, C310, C312, C341-C349, C384, C400-C403, C441-C443, C445-C447, C471-C472, C491-C492, C500-C509, C569, C570, C620-C629 C630-C631, C649, C659, C669, C690-C699, C700, C710-C714, C722-C725, C740-C749, or C754.

LIST OF PAIRED ORGANS
ICD-O

Code	Site
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS

C30.0	Nasal cavity (excluding nasal cartilage and nasal septum - use code 0)
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina - use code 0)
C34.1	Upper lobe, lung
C34.2	Middle lobe, lung
C34.3	Lower lobe, lung
C34.8	Other parts of lung or bronchus
C34.9	Lung, NOS
C38.4	Pleura
C40.0	Long bones of upper limb and scapula
C40.1	Short bones of upper limb
C40.2	Long bones of lower limb
C40.3	Short bones of lower limb
C41.3	Rib and clavicle (excluding sternum - use code 0)
C41.4	Pelvic bones (excluding sacrum, coccyx, and symphysis pubis - use code 0)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face (if midline, code 5)
C44.5	Skin of trunk (if midline, code 5)
C44.6	Skin of arm and shoulder
C44.7	Skin of leg and hip

C47.1	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C49.1	Connective, subcutaneous, and other soft tissue of upper limb and shoulder
C49.2	Connective, subcutaneous, and other soft tissue of lower limb and hip
C50.0-C50.9	Breast (male and female)
C56.9	Ovary
C57.0	Fallopian tube
C62.0	Undescended testis
C62.1	Descended testis
C62.9	Testis, NOS
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0-C69.9	Eye and lacrimal gland
C70.0	Cerebral meninges
C71.0	Cerebrum
C71.1	Frontal lobe
C71.2	Temporal lobe
C71.3	Parietal lobe
C71.4	Occipital lobe
C72.2	Olfactory nerve
C72.3	Optic nerve
C72.4	Acoustic nerve
C72.5	Cranial nerve, NOS

C74.0-C74.9	Suprarenal gland
C75.4	Carotid body

30420 - Multiplicity Counter

Field Length: 2

This data item is optional effective with 01/01/2013 diagnoses, but remain required for diagnoses in 2007-2012.

This data item is effective with cases diagnosed January 1, 2007, and later. It is used to count the number of tumors (multiplicity) reported as a single primary. Use the multiple primary rules for the specific site to determine whether the tumors are a single primary or multiple primaries.

Coding Instructions

1. Code the number of tumors being abstracted as a single primary.
2. Do not count metastasis.
3. When there is a tumor or tumors with separate single or multiple foci, ignore/do not count the foci.
4. Use code 01 when:
    a. There is a single tumor in the primary site being abstracted
    b. There is a single tumor with separate foci of tumor
5. Use code 88 for:
    a. Leukemia
    b. Lymphoma
    c. Immunoproliferative diseases
    d. Unknown primary
6. Use code 99 when:
    a. The original pathology report is not available and the documentation does not specify whether there was a single or multiple tumors in the primary site
    b. The tumor is described as multifocal or multicentric and the number of tumors is not mentioned
    c. The tumor is described as diffuse
    d. The operative or pathology report describes multiple tumors but does not give an exact number
    e. It is unknown if there is a single tumor or multiple tumors and the multiple primary rules instructed you to default to a single tumor
7. Leave this field blank for cases diagnosed prior to 1/1/2007.

Codes

Code	Description
00	No primary tumor identified (effective for cases diagnosed 1/1/2011 forward)
01	One tumor only
02	Two tumors present

03	Three tumors present
88	Information on multiple tumors not collected/not applicable for this site
99	Multiple tumors present, unknown how many

Example 1: The patient has a 2cm infiltrating duct carcinoma in the LIQ and a 1cm infiltrating duct carcinoma in the UIQ of the left breast. Accession as a single primary and enter 02 in the data item Multiplicity Counter.
Example 2: Operative report for TURB mentions multiple bladder tumors. Pathology report: Papillary transitional cell carcinoma present in tissue from bladder neck, dome, and posterior wall. Record 99 (multiple tumors, unknown how many) in Multiplicity Counter.
Example 3: Pathology from colon resection shows a 3cm adenocarcinoma in the ascending colon. Biopsy of liver shows a solitary metastatic lesion compatible with the colon primary. Record 01 in Multiplicity Counter (do not count the metastatic lesion).
Example 4: Patient has an excisional biopsy of the soft palate. The pathology shows clear margins. Record 01 in the Multiplicity Counter. Within six months another lesion is excised from the soft palate. Use the head and neck multiple primary rules to determine this tumor is not accessioned as a second primary. Change the Multiplicity Counter to code 02 to reflect the fact that there were two separate tumors abstracted as a single primary.
Example 5: CT of chest shows two lesions in the left lung and a single lesion in the right lung. Biopsy of the right lung lesions shows adenocarcinoma. No other workup is done. Using the multiple primary rules for lung, the case is abstracted a single primary. Enter the number 03 in the data item Multiplicity Counter.

30430 - Date of Multiple Tumors

Field Length: 8

This data item is optional effective with 01/01/2013 diagnoses, but remain required for diagnoses in 2007-2012.

This data item is effective with cases diagnosed January 1, 2007 onward. It is used to identify the month, day, and year the patient is diagnosed with multiple tumors reported as a single primary. Use the multiple primary rules for that specific site to determine whether the tumors are a single primary or multiple primaries.

Date
Record the date in month, day, year format (MMDDCCYY) that the patient was diagnosed with multiple tumors reported as a single primary.

Special Codes

Code	Description
00000000	Single tumor
88888888	Information regarding multiple tumors is not applicable for this cancer (lymphoma, leukemia, immunoproliferative disease, and unknown primary)
99999999	Unknown date

Coding Instructions
1. When multiple tumors are present at diagnosis, record the date of diagnosis.
Example 1: The patient has multiple tumors; a 2cm infiltrating duct carcinoma in the LIQ and a 1cm infiltrating duct carcinoma in the UIQ of the left breast. According to the breast multiple primary rules, these tumors are accessioned as a single primary. Enter the date of diagnosis in Date of Multiple Tumors.
Example 2: Operative report for TURB mentions multiple bladder tumors. Pathology report: Papillary transitional cell carcinoma present in tissue from bladder neck, dome, and posterior wall. According to the Bladder, Renal Pelvis, and Ureter multiple primary rules these tumors are accessioned as a single primary. Enter the date of diagnosis in Date of Multiple Tumors.
2. When subsequent tumor(s) are counted as the same primary, record the date the second/subsequent tumor was diagnosed. Update the multiplicity counter at this time.
Example: Patient has an excisional biopsy of a single tumor in the soft palate on January 2, 2007. The pathology shows clear margins. Record 01 in the Multiplicity Counter field. On July 10, 2007, another tumor is excised from the soft palate. The multiple primary rules for head and

neck state that this tumor is the same primary. Change the 01 in Multiplicity Counter to 02 and enter 07102007, the date the second tumor was diagnosed, in Date of Multiple Tumors.
3. Leave this field blank for cases diagnosed prior to 1/1/2007.

30431 - Date of Multiple Tumors Flag

Field Length: 2

This is a calculated field which explains why there is no appropriate value in the field Date of Multiple Tumors (item #30430). This item is blank for cases diagnosed prior to January 1, 2007.

Codes

Code	Description
11	No proper value is applicable in this context (for example, multiple tumors are not collected for this site and histology)
12	A proper value is applicable but not known (that is, the date of multiple tumors is unknown)
15	A single tumor only
(blank)	A valid date value is provided

30440 - Type of Multiple Tumors Reported as One Primary

Item Length: 2

This data item is optional effective with 01/01/2013 diagnoses, but remain required for diagnoses in 2007-2012.

This data item is effective with cases diagnosed January 1, 2007 onward. Code the type of multiple tumors that are abstracted as a single primary. Ignore metastatic tumors for this data item.

Code	Code Text	Description	Example(s)
00	Single tumor	All single tumors. Includes single tumors with both in situ and invasive components	Code 01 in the Multiplicity Counter
10	Multiple benign	At least two benign tumors in same organ/primary site Use this code for reportable tumors in intracranial and CNS sites only May be used for reportable by agreement cases	
11	Multiple borderline	At least two borderline tumors in the same organ/primary site Use this code for reportable tumors in intracranial and CNS sites only May be used for reportable by agreement cases	
12	Benign and borderline	At least one benign AND at least one borderline tumor in the same organ/site group Use this code for reportable tumors in intracranial and CNS sites only May be used for reportable by agreement cases	

20	Multiple in situ	At least two in situ tumors in the same organ/primary site	Cystoscopy reports documents multiple bladder tumors. Pathology: flat transitional cell carcinoma of bladder.
30	In situ and invasive	One or more in situ tumor(s) AND one or more invasive tumors in the same organ/primary site	
31	Polyp and adenocarcinoma	One or more polyps with either · In situ carcinoma or · Invasive carcinoma AND one or more frank adenocarcinoma(s) in the same segment of colon, rectosigmoid, and/or rectum	
32	FAP with carcinoma	Diagnosis of familial polyposis (FAP) AND carcinoma (in situ or invasive) is present in at least one of the polyps	
40	Multiple invasive	At least two invasive tumors in the same organ	
80	Unknown in situ or invasive	Multiple tumors present in the same organ/primary site, unknown if in situ or invasive	
88	N/A	Information on multiple tumors not collected/not applicable for this site	Leukemia, lymphoma, immunoproliferative diseases, and unknown primaries. All codes 88 in Multiplicity Counter
99	Unknown	Unknown	Code 99 in Multiplicity Counter, and DCO cases

30450 - AMBIGUOUS TERMINOLOGY

Item Length: 1

This data item is optional effective with 01/01/2013 diagnoses, but remain required for diagnoses in 2007-2012.

This data item is collected effective with diagnoses on or after January 1, 2007. It identifies all cases, including DCO and autopsy only, which are accessioned based only on ambiguous terminology. Registrars are required to collect cases based on ambiguous terminology in the diagnosis and it is advantageous to be able to identify those cases in the database.

Definitions

Phrase	Definition	Examples
Ambiguous terminology	Terms which have been mandated as reportable when used in a diagnosis. See page 3 of the FORDS Manual for detailed instructions on how to use the list.	**Clinical:** a physician's statement that the patient most likely has lung cancer. **Laboratory tests:** A CBC suspicious for leukemia. **Pathology:** A prostate biopsy compatible with adenocarcinoma.
Conclusive terminology	A clear and definite statement of cancer. The statement may be from a physician (clinical diagnosis), or may be from a laboratory test, autopsy, cytologic findings, and/or pathology.	**Clinical:** a physician's statement that the patient has lung cancer. **Laboratory tests:** A CBC diagnostic of acute leukemia. **Cytologic findings:** A FNA (fine needle aspiration) with findings of infiltrating duct carcinoma of the breast. **Pathology:** A colon biopsy showing adenocarcinoma.

List of Ambiguous Terms

Apparent(ly)	Most likely
Appears	Presumed
Comparable with	Probable
Compatible with	Suspect(ed)
Consistent with	Suspicious (for)
Favor(s)	Typical (of)

Malignant appearing

Code	Label	Definition	Time Frame
0	Conclusive term	There was a conclusive diagnosis within 60 days of the original diagnosis. Case was accessioned based on conclusive terminology. Includes all diagnostic methods such as clinical diagnosis, cytology, pathology, etc.	Within 60 days of the date of initial diagnosis
1	Ambiguous term only	The case was accessioned based only on ambiguous terminology. There was not conclusive terminology during the first 60 days following the initial diagnosis. Includes all diagnostic methods except cytology. *Note*: Cytology is excluded because registrars are not required to collect cases with ambiguous terms describing a cytology diagnosis.	N/A
2	Ambiguous term followed by conclusive term	The case was originally assigned a code 1 (was accessioned based only on ambiguous terminology). More than 60 days after the initial diagnosis, the information is being updated to show that a	60 days or more after the date of diagnosis

		conclusive diagnosis was made by any diagnostic method including clinical diagnosis, cytology, pathology, autopsy, etc.	
9	Unknown term	There is no information about ambiguous terminology.	N/A

Coding Instructions

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

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

3. Use code 2 when a case is accessioned based on ambiguous terminology followed by clear and definite more than 60 days after the initial diagnosis.

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

5. Leave this data item blank for cases diagnosed prior to 1/1/2007.

6. Cases accessioned based on ambiguous terminology (code 1) should be excluded from case selection in research studies. Direct patient contact is not recommended.

30460 - DATE OF CONCLUSIVE TERMINOLOGY

Item Length: 8

This data item is optional effective with 01/01/2013 diagnoses, but remain required for diagnoses in 2007-2012.

This data item is effective with cases diagnosed on or after January 1, 2007. For those cases originally accessioned based on ambiguous terminology only, this data item documents the date of a definite statement of malignancy. The abstractor will change the code for the data item Ambiguous Terminology from a 1 to a 2 and enter the date that the malignancy was described clearly and definitely in the Date of Conclusive Terminology.

Date
Record the date in month, day, year format (MMDDCCYY) that the malignancy was described with conclusive terminology at least 60 days after it was initially diagnosed by ambiguous terminology.

Special Codes

Codes	Description
00000000	Based on **ambiguous terminology only** (Code 1 in data item "Ambiguous Terminology")
88888888	Not applicable; based on conclusive diagnosis within 60 days (Code 0 in data item "Ambiguous Terminology")
99999999	Unknown date; unknown if diagnosis was based on ambiguous terminology or conclusive terminology (Code 9 in data item "Ambiguous Terminology")

Leave this field blank for cases diagnosed prior to 1/1/2007.

30461 - Date of Conclusive Terminology Flag

Field Length: 2

This is a calculated field which explains why there is no appropriate value in the field Date of Conclusive Terminology (item #30460). This item is blank for cases diagnosed prior to January 1, 2007.

Codes

Code	Definition
10	No information whatsoever can be inferred (for example, unknown if the diagnosis was initially based on ambiguous terminology)
11	No proper value is applicable in this context (for example, initial diagnosis made by unambiguous terminology)
12	A proper value is applicable but not known (that is, the date of conclusive diagnosis is unknown)
15	Accessioned based on ambiguous terminology only
(blank)	A valid date value is provided

30470 - DIAGNOSTIC CONFIRMATION

Field Length: 1

Instructions for coding solid tumors (all tumors *except* 9590-9992)

- The codes are in priority order; code 1 has the highest priority. Always code the procedure with the **lower** numeric value when presence of cancer is confirmed with multiple diagnostic methods. This item is an indicator of the precision of diagnosis. The percentage of solid tumors that are clinically diagnosed is only an indication of whether casefinding includes sources beyond pathology reports. Complete casefinding must include both clinically and pathologically confirmed cases. Record the best mode of diagnostic confirmation recorded at **any time** in the patient's history of this cancer.

Code	Label	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined). Microscopic diagnosis based on tissue specimens from biopsy, frozen section, surgery, autopsy, D&C, or from aspiration or biopsy of bone marrow specimens.
2	Positive cytology	Cytologic confirmation (fluid cells microscopically examined). Microscopic diagnosis based on examination of cells such as sputum smears, bronchial brushings or washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical or vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if tissue or cells were examined.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer based on laboratory tests/marker studies which are clinically diagnostic for cancer. Examples include AFP for liver cancer and abnormal electrophoretic spike for mulitple myeloma. Note: elevated PSA is *only* diagnostic of cancer if the physician uses the PSA as a basis for diagnosing prostate cancer with no further workup.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure with no tissue resected for microscopic examination. Use this code when the diagnosis is based only on the surgeon's operative report from a surgical exploration or endoscopy, or from gross autopsy findings in the absence of tissue or cytological findings.

7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only	The malignancy was reported by the physician in the medical record. If a physician treats a patient for cancer, in spite of a negative biopsy, this is a reportable clinical diagnosis. Also, if a physician continues to describe a patient as having a reportable tumor, even after reviewing negative pathology results, this too is a reportable clinical diagnosis.
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed.

Instructions for coding hematopoietic or lymphoid tumors (9590-9992)

- There is no priority hierarchy for coding diagnostic confirmation for hematopoietic and lymphoid tumors. Code this field according the definitive diagnostic method used to confirm this malignancy. Definitive diagnostic methods are displayed in the hematopoietic database for each reportable hematopoietic and lymphoid neoplasm. Use code 3 whenever it applies-- i.e., whenever a positive histologic diagnosis is supported by a further positive test, such as IHC or genetic testing

Code	Label	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined). Microscopic diagnosis based on tissue specimens from biopsy, frozen section, surgery, autopsy, or bone marrow aspiration or biopsy. For leukemia only, code 1 when the diagnosis is based only on the complete blood count (CBC), white blood count (WBC), or peripheral blood (PB) smear.
2	Positive cytology	Cytologic confirmation (fluid cells microscopically examined). Microscopic diagnosis based on examination of cells such as spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical or vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. These methods are rarely used for hematopoietic or lymphoid tumors.
3	Positive histology PLUS positive immunophenotyping	Histology is positive for cancer, and there are also positive immunophenotyping and/or genetic test results. For example, bone marrow examination is positive for AML (9861/3). Genetic testing

	and/or positive genetic studies	shows AML with inv(16)p13.1q22) (9871/3). Do not use this code for neoplasms diagnosed prior to January 1, 2010.
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if tissue or cells were examined.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination. Use this code when the diagnosis is based only on the surgeon's operative report from a surgical exploration or endoscopy, or from gross autopsy findings in the absence of tissue or cytological findings.
7	Radiography and other imaging techniques without microscopic examination	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only	The malignancy was reported by the physician in the medical record. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient's clinical presentation.
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed.

30480 - Pathology Report Number

Field Length: 15

Record the pathology report number from which the diagnosis of cancer was made. The field allows for 15 characters - start entering in the left most box and leave any trailing boxes blank.

SEER Extent of Disease

NOTE: This EOD coding scheme is required by KCR for cases diagnosed from January 1, 2000 through December 31, 2003. As of January 1, 2004, data in fields 30490-30530 - Tumor Size, SEER Extent, Pathologic Extent for Prostate, and SEER Lymph Node Involvement - will no longer be collected. Instead, this information will be captured in the Collaborative Stage fields 30540-30680.

The extent of disease scheme used for cases diagnosed after 1988 by SEER is composed of:

Size of Primary Tumor (3 digits)
Extension (2 digits) plus 2 additional digits for prostate pathologic extent
Lymph Nodes (1 digit)
Number of Positive Regional Lymph Nodes (2 digits)
Number of Regional Lymph Nodes Examined (2 digits)

The codes and coding instructions for the SEER Extent of Disease--1988 are detailed in SEER Extent of Disease Codes-- 1988, Codes and Coding Instructions, third edition (revised in 1998). This reference contains the site specific codes for items 30490, 30510, 30520, and 30530: tumor size, SEER extension, prostate pathologic extent, and lymph node involvement.

Extent of Disease should include all information available within four months of diagnosis in the absence of disease progression or through completion of surgery(ies) in first course treatment, whichever is longer. **Except for tumor size, Extent of Disease information obtained after treatment with neoadjuvant chemotherapy, radiation therapy, hormonal therapy, or immunotherapy may be included**.

All schemes apply to all histologies, unless otherwise noted.

The priority for using information is pathologic, operative and clinical findings.

For "Death Certificate Only" cases, this field is to be coded '999999999' except for death certificate only prostate cases, which are coded '999909999990'.

30490 - Tumor Size

Field Length: 3

DO NOT CODE THIS FIELD FOR CANCERS DIAGNOSED ON OR AFTER 1-1-2004. INSTEAD, RECORD TUMOR SIZE IN ITEM 30540 ACCORDING TO INSTRUCTIONS IN THE COLLABORATIVE STAGING MANUAL.

If the diagnosis date is before 1-1-2004, record the size of the tumor here in millimeters as stated in the pathology report. If more than one dimension is recorded, code the greatest one. For example, 6.1 x 9.4 cm should be recorded as 094. To convert centimeters to millimeters, multiply centimeters by 10. If the tumor size is stated in millimeters, such as "breast tumor is 13 mm," code as 013.

Use the instructions in the *SEER Extent of Disease 1998 Codes and Coding Instructions* manual, pages 3-5 and the tables that follow, to code this field.

If the pathology report does not specify tumor size, a reasonable estimate should be entered from the surgical notes, from scans or radiologic reports, or other clinical findings in that order. If unknown, code '999'.

Use the charts and tables on the following pages for additional guidelines in coding this field.

EXCEPTIONS: For melanomas of the skin, vulva, penis, scrotum, and conjunctiva, use this field to record the DEPTH OF INVASION (thickness of tumor) - and not largest tumor dimension - in HUNDREDTHS OF MILLIMETERS. For example, a melanoma with 1.55 mm depth of invasion should be coded 155. A melanoma of 9.9 mm or greater should be coded 990.

For melanomas of the uvea and other parts of the eye (C69.1-C69.4, C69.8-C69.9), as well as any other anatomic sites, record the tumor size at largest dimension and not depth of invasion.

For mycosis fungoides and Sezary's disease, use this field to record PERIPHERAL BLOOD INVOLVEMENT instead of tumor size.

For Hodgkin's and non-Hodgkin's lymphomas and Kaposi's sarcoma, use this field to record HIV STATUS instead of tumor size.

You may round off if the size is more precise than the coding spaces available.
For example: -ovarian tumor is 16.75 cm - code 168
-skin melanoma is 4.668 mm thick - code 467

Find the type of cancer you are abstracting in the left column. Then follow across the row to see the instructions for coding the field 'Tumor Size' for that type of cancer.

TYPE OF CANCER	ABSTRACTING GUIDELINES
1. Melanoma (8720- 8790) of skin (C44.0-C44.9) of vulva (C51.0-C51.9) of penis (C60.0-C60.9) of scrotum (C63.2) of conjunctiva (C69.0)	***Code thickness*** (depth of invasion of tumor) ***Code in hundredths of millimeters*** Examples: thickness of .75mm = 075 = T1 if skin thickness of 2.5mm = 250 = T3 if skin thickness of 4.4mm = 440 = T4 if skin thickness of 9.9mm or greater = 990
2. Hodgkins Lymphoma (9650-9667) Non-Hodgkins Lymphoma (9590-9595, 9670-9717) Kaposi's Sarcoma (9140)	Code HIV/AIDS status 001 = Yes, present 002 = No 999 = Unknown
3. Mycosis Fungoides (9700) Sezary's Disease (9701) of skin (C44.0-C44.9) of vulva (C51.0-C51.9) of penis (C60.0-C60.9) of scrotum (C63.2)	Code peripheral blood involvement 000 No peripheral blood involvement 001 <5% atypical circulating cells 002 >5% atypical circulating cells 003 % not stated 999 Not applicable
4. Malignant histocytosis (9720) Letterer-Siwe's disease (9722) True histiocytic lymphoma (9723) Plasma cell tumors (9731-9732) Leukemia (9800-9941) Immunoproliferative disease (9760-9768) Myeloproliferative disease (9950-9989) Ill defined primary site (C76.0-C76.9) C42._ and any malignancy not listed above Unknown primary site (C80.9)	Code 999 = Not applicable

5. All tumors other than those listed above on lines 1-4, ***including melanomas of sites other than skin***, vulva, penis, scrotum, and conjunctiva.	Code size of primary tumor at largest dimension. Code ***in millimeters***. There are special meanings for certain codes 001 = microscopic focus or foci 002 = 2mm or less for all sites except breast & lung 002 = (for breast) mammography dx only; no size given 002 = (for lung) malig. cells in secretions 003 = (for breast & lung) 3 mm or less 999 = tumor size not given Examples: tumor is 5mm x 2mm = 005 tumor is 5cm x 2cm = 050 tumor is 10.6cm = 106

WEIGHTS AND MEASURES*

SIZES IN CENTIMETERS, MILLIMETERS, INCHES

10 mm = 1 cm 1 cm = 10 mm
2.5 cm = 1 inch 1 inch = 025 mm

DESCRIPTIONS OF TUMOR SIZES INTERPRETED IN MM'S

Fruits		Miscellaneous Food	
Apple	070	Doughnut	090
Apricot	040	Egg	050
Cherry	020	Egg, goose	070
Date	040	Egg, hen	050
Fig, dried	040	Egg, bantam	040
Grape	020	Egg, pigeon	030
Grapefruit	010	Egg, robin	020
Kumquat	050	Lentil	009
Lemon	080	Millet	009
Lime	060		
Olive	020		
Orange	090	Money	
Peach	060		
Pear	090	Dime	010
Plum	030	Dollar, silver	040
Tangerine	060	Dollar, half	030

Nickel	020
Quarter	020
Penny	010

Nuts

Almond	030
Chestnut	040
Chestnut, horse	040
Hazel	020
Hickory	030
Peanut	010
Pecan	030
Walnut	030
Bean	010
Bean, Lima	020
Pea	009
Pea, split	009

Other

Ball, golf	040
Ball, ping pong	030
Baseball	070
Eraser or Pencil	010
Fist	090
Marble	010
Match Head	009
Microscopic focus	001

* From Seer Informational Guidebook Training Aids

30500 - EOD Coding System

Field Length: 1

This is a calculated field which indicates the type of SEER EOD code (based on the year of diagnosis) applied to the tumor. This field is blank for cases diagnosed after January 1, 2004.

30510 - SEER Extension

Field Length: 2

> (Required field with all cases diagnosed from January 1, 2000 to December 31, 2003.)
> **As of 1-1-2004, leave this field blank and code information in the Collaborative Stage item #30540 instead.**

Code the farthest documented extension of tumor away from the primary site, either by contiguous extension or distant metastasis.

The description of the primary tumor growth within the organ of origin or its extension to neighboring organs, or its metastasis to distant sites is summarized in a two-digit code. It is a hierarchical code in which the most extensive disease is all that is coded. Thus, information about the extent of the tumor within the primary site is lost if the tumor extends to neighboring organs, and extension to neighboring organs is lost if there is distant metastasis. Code '99' is reserved for unknown extension, except for prostate.

Use the instructions in the *SEER Extent of Disease 1998 Codes and Coding Instructions* manual, page 7, and the tables that follow, to code this field.

This field must match the behavior code. If behavior is /2, this data element must be coded in-situ\non-invasive (00, 01, 02, 03, 04, 05).

30520 - PATHOLOGIC EXTENT - PROSTATE

Field Length: 2

DO NOT CODE THIS FIELD IF THE DIAGNOSIS DATE IS ON OR AFTER 1-1-2004. Record the pathologic extent for a prostate cancer in the Collaborative Stage, Site Specific Factor 3 field instead.

If the diagnosis date is before 1-1-2004, record the EOD extent code based on information obtained from a prostatectomy, for prostate primaries only. Record '99' if no prostatectomy was done as part of first course therapy. Leave blank for all other types of cancer.

30530 - SEER LYMPH NODE INVOLVEMENT

Field Length: 1

(Required field with all cases diagnosed from January 1, 2000 to December 31, 2003.)
As of 1-1-2004, leave this field blank and record this information in the Collaborative Stage Item #30570 instead.

If the diagnosis date is before 1-1-2004, record the highest specific lymph node chain that is involved by tumor.

Use the instructions in the *SEER Extent of Disease 1998 Codes and Coding Instructions* manual, pages 8-9, and the tables that follow, to code this field.

Nodes which are considered "regional nodes" are defined by primary site in the AJCC *Manual for Staging of Cancer*.

30540-32810 - COLLABORATIVE STAGING

Collaborative Staging (CS) is to be used for cases diagnosed on or after January 1, 2004. It is not to be used for cases diagnosed prior to that date. Its introduction does not affect CoC requirements for physicians to assign AJCC staging or the requirement that the physician-assigned staging values be recorded in the registry. CS Version 2 was implemented in 2010, and all cases previously entered under CS Version 1 were converted to CSv2.

Collaborative Staging was designed for registrar use. For Collaborative Staging, registrars code discrete pieces of information once and the CS computer algorithm derives the values for AJCC T, N, M and Stage Group, Summary Stage 1977, and Summary Stage 2000. The derived stage codes are ideally suited for data analysis because of the consistency that can be obtained with objectively-recorded, identically-processed data items.

The timing rule for CS coding was designed to make use of the most complete information possible to yield the ”best stage” information for the tumor at the time of diagnosis-- "use all information gathered through completion of surgery(ies) in first course of treatment or all information available within four months of the date of diagnosis in the absence of disease progression, whichever is *longer*." Disease progression is defined as further direct extension or distant metastasis known to have developed after the diagnosis was established. Information about tumor extension, lymph node involvement, or distant metastasis obtained after disease progression is documented should be excluded from the CS coding.

The following CS data items are coded by the registrar.

30540. CS Tumor Size
30550. CS Extension
30560. CS Tumor Size/Ext Eval
30570. CS Lymph Nodes
30580. CS Reg Lymph Nodes Eval
30590. Regional Lymph Nodes Examined
30600. Regional Lymph Nodes Positive
30610. CS Mets at DX
30620. CS Mets Eval
30621. CS Mets at Diag-Bone
30622. CS Mets at Diag-Brain
30623. CS Mets at Diag-Liver
30624. CS Mets at Diag-Lung
30630-30680. CS Site-Specific Factors 1-6
32520-32700 CS Site-Specific Factors 7-25

The CS algorithm produces the output items listed below. The derived AJCC items are separate from the physician-coded items; and the derived Summary Stage items are separate from the manually-coded items collected by the CoC in the past. The derived items cannot be manually entered.

30780. Derived AJCC 6 T Descriptor
30790. Derived AJCC 6 T Code
30800. Derived AJCC 6 T Text
30810. Derived AJCC 6 N Descriptor
30820. Derived AJCC 6 N Code
30830. Derived AJCC 6 N Text
30840. Derived AJCC 6 M Descriptor
30850. Derived AJCC 6 M Code
30860. Derived AJCC 6 M Text
30870. Derived AJCC 6 Stage Group Code
30880. Derived AJCC 6 Stage Group
32710. Derived AJCC 7 T Descriptor
32720. Derived AJCC 7 T Code
32730. Derived AJCC 7 T Text
32740. Derived AJCC 7 N Descriptor
32750. Derived AJCC 7 N Code
32760. Derived AJCC 7 N Text
32770. Derived AJCC 7 M Descriptor
32780. Derived AJCC 7 M Code
32790. Derived AJCC 7 M Text
32800. Derived AJCC 7 Stage Group Code
32810. Derived AJCC 7 Stage Group
30690. Derived SS1977
30710. Derived SS2000

Unlike the AJCC and Summary Stage codes that are derived from it, CS is more of a site-specific data collection system. The CS algorithm uses tumor site and histology to determine which CS schema to apply. Depending on the schema, the coding instructions and code definitions will vary. Collaborative Staging codes are defined for every site and histology combination. The AJCC *Cancer Staging Manual* does not cover all sites, and some histologies are excluded from sites with an AJCC coding scheme. When the CS algorithm processes a site-histology combination that does not have an applicable AJCC code, it assigns the display string "NA" for "Not applicable." A blank display string for a derived item means the CS algorithm was not run for the case.

Coding CS Items

The complete instructions and site-histology defined codes are available in the *Collaborative Stage Data Collection System Coding Instructions (CS Manual).* Effective 01/01/2014, CS version 02.05 was implemented. Part I, Section 1 provides general instructions and the instructions and codes for generic (non site-specific) items. Part I, Section 2 contains lab tests, tumor markers, and site specific factor notes. Part II contains the site-specific schemas and codes. The *CS Manual* and related information is available electronically on the AJCC Web site: http://cancerstaging.org/cstage/Pages/default.aspx. For an easily navigable web-based list

of site-specific schema and coding instructions, go to http://cancerstaging.org/cstage/schema/Pages/version0205.aspx Use the downloadable manual as well as the website to view the notes and appropriate codes for each schema.

Begin assigning codes for the Collaborative Staging data items. Be sure to read the notes and follow the site/histology-specific instructions at the beginning of each item. Some schemas require additional staging or prognostic information for that particular site. *CS Site-Specific Factors 1-25* are designed to collect that information.

- Code the tumor size in the *CS Tumor Size* item.
- Code how far the tumor has spread directly in the *CS Extension* item.
- Code how the farthest tumor spread was determined in the *CS Tumor Size/Ext Eval* item.
- Code whether regional lymph nodes are involved in the *CS Lymph Nodes* item.
- Code how the farthest lymph node spread was determined in the *CS Reg Node Eval* item.
- Code the number of positive regional lymph nodes from the pathology report in the *Regional Nodes Positive* item.
- Code the number of regional lymph nodes examined by the pathologist in the *Regional Nodes Examined* item.
- Code the farthest distant metastasis (including distant lymph nodes) in the *CS Mets at Dx* item.
- Code how the distant metastasis was determined in the *CS Mets Eval* item.
- Code the presence or absence of bone, brain, liver, or lung metastases.
- Code all required *CS Site-Specific Factors*.

The derived stage information for AJCC 6th edition staging will be calculated when the case is saved, or prior to exiting the case. The derived stage information for AJCC 7th edition will only be calculated for cases diagnosed January 1, 2010, forward. When the computer derives the final stage information, the program will check the histology code and other coded information to determine whether T, N, M and Stage Group will be generated for the case. If the histology code is not in that schema's inclusion list for that site, the T, N, M, and Stage Group will be reported as "Not Applicable." Summary Stage is generated for every case.

30690 - SUMMARY STAGE 1977

Field Length: 1

For cases diagnosed after 1-1-2004, this field will be calculated from the Collaborative Stage data items.
For cases diagnosed from 1-1-2001 to 12-31-2003, this field will be calculated from the SEER Extent of Disease data items.

For cases diagnosed prior to January 1, 2001, record the one digit code which describes the stage of disease at time of initial diagnosis and/or first treatment. Use all information available in the medical record within four months of the date of diagnosis in the absence of disease progression or through completion of first course surgery(ies), whichever is longer. Note that often surgical procedures will reveal the true anatomic extent of the disease at the time of first treatment and this information may be used in staging this case.

Refer to the Summary Staging Guide of the SEER Program to determine the general stage. Briefly described, they are:

Code	Description
0	In-situ/non-invasive malignant tumor. The pathology report must state "in-situ". In addition there must be no evidence of invasion mentioned anywhere in the record in order for a tumor to be staged in this category. (The following synonyms may also be used instead of "in-situ": intraepithelial, intraepidermal, non-infiltrating, intraductal, or Bowen's Disease.)
1	Localized - tumor is confined to the organ of origin.
2	Regional by direct extension - tumor has spread by direct extension to immediately adjacent tissues or organs.
3	Regional to lymph nodes - tumor has spread into lymph nodes regional to the primary site of origin.
4	Regional by both direct extension and regional lymph nodes.
5	Regional, NOS - tumor is regionally spread, but the extent of regional spread cannot be determined, or is not specified.
7	Distant metastasis - a tumor that has spread beyond the immediately adjacent tissues and has developed secondary or metastatic tumors, has seeding or implants, or is systemic. Leukemia, multiple myeloma, reticuloendotheliosis, hematopoietic diseases, and Letterer-Siwe's disease are always coded 7.
9	Unknown/Unstageable - Use when there is not enough information available to accurately determine the stage. Every effort should be made to determine the stage by thoroughly reviewing the record or obtaining information from a medical authority before using code 9.

Code '9' should be used for unknown primaries, because staging for these cases is not applicable.

In the case of patients first treated elsewhere and admitted to your hospital for a subsequent course of treatment, enter the stage at the time of initial diagnosis, if it is known. If not, record the stage as "Unknown". Do not record the stage at the time of admission to your hospital for subsequent treatment.

30700 - Summary Stage 1977 Display String

Field Length: 5

This is the label which appears on screen or in reports and that corresponds to the code stored in Summary Stage 1977 (item #30690).

Code	Display String
0	IS
1	L
2	RE
3	RN
4	RE+RN
5	RNOS
7	D
8	NA
9	U

30710 - SUMMARY STAGE 2000

Field Length: 1

This is a one digit code which summarizes the stage of disease at time of initial diagnosis and/or first treatment. It only applies to cancers diagnosed on or after January 1, 2001. It will be calculated based on information coded in the SEER Extent of Disease fields for cases diagnosed from 1-1-2001 to 12-31-2003. For cases diagnosed on or after 1-1-2004, it will be calculated from the Collaborative Stage data items.

Refer to the Summary Staging Guide of the SEER Program to determine the general stage. Briefly described, they are:

Code	Description
0	In-situ/non-invasive malignant tumor. The pathology report must state "in-situ". In addition there must be no evidence of invasion mentioned anywhere in the record in order for a tumor to be staged in this category. (The following synonyms may also be used instead of "in-situ": intraepithelial, intraepidermal, non-infiltrating, intraductal, or Bowen's Disease.)
1	Localized - tumor is confined to the organ of origin.
2	Regional by direct extension - tumor has spread by direct extension to immediately adjacent tissues or organs.
3	Regional to lymph nodes - tumor has spread into lymph nodes regional to the primary site of origin.
4	Regional by both direct extension and regional lymph nodes.
5	Regional, NOS - tumor is regionally spread, but the extent of regional spread cannot be determined, or is not specified.
7	Distant metastasis - a tumor that has spread beyond the immediately adjacent tissues and has developed secondary or metastatic tumors, has seeding or implants, or is systemic. Leukemia, multiple myeloma, reticuloendotheliosis, hematopoietic diseases, and Letterer-Siwe's disease are always coded 7.
8	Not applicable - For non malignant (benign or borderline) tumors of the CNS----This code is never used to stage malignant tumors.
9	Unknown/Unstageable - Use when there is not enough information available to accurately determine the stage. Every effort should be made to determine the stage by thoroughly reviewing the record or obtaining information from a medical authority before using code 9.

Code '9' should be used for unknown primaries, because staging for these cases is not applicable.

In the case of patients first treated elsewhere and admitted to your hospital for a subsequent course of treatment, enter the stage at the time of initial diagnosis, if it is known. If not, record the stage as "Unknown". Do not record the stage at the time of admission to your hospital for subsequent treatment.

30720 - Summary Stage 2000 Display String

Field Length: 5

This is the label which appears on screen or in reports and that corresponds to the code stored in Summary Stage 2000 (item #30710).

Code	Display String
0	IS
1	L
2	RE
3	RN
4	RE+RN
5	RNOS
7	D
8	NA
9	U

30730-30770 - Sites of Distant Metastases

Field Length: 2 (x 5)

Record the appropriate code(s) for up to five sites of distant metastases present at the time of initial diagnosis. Include a distant site here if it is considered metastatic by the AJCC *Manual for Staging of Cancer*. See Appendix E for General Sites Codes.

The following systemic diseases should not have sites of metastases recorded: leukemia, Letterer-Siwe disease, multiple myeloma, reticuloendotheliosis, Hodgkin's and Non-Hodgkin's lymphomas, and unknown primaries.

When you are abstracting an unknown primary, you may not code site(s) of metastases here, because you cannot be sure they are distant sites.

Precede any single digit codes with a zero.

30920 - CS VERSION LATEST (DERIVED)

Field Length: 6

This field does not appear on the patient abstract, but is available for data analysis. It is a computer assigned value which is recorded the first time the Collaborative Stage output fields are derived and is updated each time the CS Derived items are recalculated.

The digits are stored as follows:

- The first two digits represent the major version number
- The third and fourth digit represent minor version changes
- The last two digits represent even less significant changes that do not affect coding

30925 - CS Version Input Current

Field Length: 6

This field does not appear on the patient abstract, but is available for data analysis. This is a calculated item which indicates the version of Collaborative Staging input fields after they have been updated or recoded. This data item is recorded when the CS input fields are initially completed and is updated each time the CS input fields are modified.

The digits are stored as follows:

- The first two digits represent the major version number
- The third and fourth digit represent minor version changes
- The last two digits represent even less significant changes that do not affect coding

30930 - CS Version Input Original

Field Length: 6

This field does not appear on the patient abstract, but is available for data analysis. It is a computer assigned value which indicates the Collaborative Staging version used to initially code the CS data items. When the CS algorithm is run and the output values stored at the time of initial abstracting, the program automatically stores the value in this field.

The digits are stored as follows:

- The first two digits represent the major version number
- The third and fourth digit represent minor version changes
- The last two digits represent even less significant changes that do not affect coding

Note: This field is not updated if the data item codes are changed.

AJCC Staging of Cancer

The extent or *stage* of cancer at the time of diagnosis is a key factor that defines prognosis and is a critical element in determining appropriate treatment based on the experience and outcomes of groups of prior patients with similar stage. In addition, accurate staging is necessary to evaluate the results of treatments and clinical trials, to facilitate the exchange and comparison of information among treatment centers, and to serve as a basis for clinical and translational cancer research. At a national and international level, the agreement on classifications of cancer cases provides a method of clearly conveying clinical experience to others without ambiguity.

The most clinically useful staging system is the tumor-node-metastatis (TNM) system maintained collaboratively by the American Joint Committee on Cancer (AJCC) and the International Union for Cancer Control (UICC). The TNM system classifies cancers by the size and extent of the primary tumor (T), involvement of regional lymph nodes (N), and the presence or absence of distant metastases (M), supplemented in recent years by carefully selected nonanatomic prognostic factors.

NOTE: The *AJCC Manual for Staging Cancer*, Third Edition is used with cases diagnosed from 1989-1992.
The *AJCC Manual for Staging Cancer*, Fourth Edition, is used with cases diagnosed from 1993 to 1997.
The *AJCC Cancer Staging Manual*, Fifth Edition, is used with cases diagnosed from 1998 to 2002.
The *AJCC Cancer Staging Manual*, Sixth Edition, is used with cases diagnosed from 2003 to 2009.
The *AJCC Cancer Staging Manual*, Seventh Edition, is used with cases diagnosed 2010 forward.

NOTE: For 2008 diagnoses forward, ACoS requires clinical TNM staging assigned by a physician if available. If not available, these fields must be completed by the registrar. Pathologic TNM is not required. For pre-2008 diagnoses, physician-assigned TNM stage is required for both clinical and pathologic staging in approved programs. Physicians may choose to record both the clinical and the pathologic stage if applicable. Registrars are required to report both if information is available from the physician. KCR requires only one TNM stage-- pathologic if the information is available, otherwise clinical.

The TNM general rules applicable to all sites contained in the Seventh Edition are as follows:

1. All cases should be confirmed microscopically for classification by TNM. Cases that do not have any biopsy or cytology of the tumor can be staged, but survival should be analyzed separately. These cases should not be included in overall disease survival analyses.

2. Eligible time period for determination of staging:
   a. Clinical staging, designated cTNM, includes any information obtained about the extent of cancer before initiation of definitive treatment (surgery, systemic or radiation therapy, active

surveillance, or palliative care) or within four months after the date of diagnosis, whichever is *shorter*, as long as the cancer has not clearly progressed during that time frame.

b. Pathologic staging, designated pTNM, includes any information obtained about the extent of cancer up through completion of definitive surgery as part of first course treatment or identified within four months after the date of diagnosis, whichever is *longer*, as long as there is no systemic or radiation therapy initiated or the cancer has not clearly progressed during that time frame.

3. Cases with neoadjuvant, or primary systemic or radiation therapy may have a second stage defined from information obtained after therapy that is recorded using a yc or yp prefix (ycTNM or ypTNM; y must always be modified as yc or yp). However, these patients should also have clinical stage recorded as this is the stage used for comparative purposes. Clinical stage includes only information collected prior to the start of treatment.

4. In cases where there is documented progression of cancer prior to the initiation of therapy or surgery, only information obtained prior to documented progression is used for staging.

5. If there is uncertainty in assigning a T, N, or M classification, a stage modifying factor (i.e., in clinical situations where it is unclear if the lymph nodes are N2 or N1), or anatomic stage/prognostic group, default to the lower (lesser) of the two categories in the uncertain range.

6. If a nonanatomic factor required for grouping is not available, the case is assigned to the group assuming that factor was the lowest or least advanced (e.g., lower Gleason's score in prostate cancer).

7. In the case of multiple, simultaneous tumors in one organ, the tumor with the highest T category should be identified and the multiplicity will be recorded in the TNM descriptor field. In simultaneous bilateral cancers of paired organs, each tumor should be classified independently if each is determined to be a separate primary. In tumors of the thyroid, liver, and ovary, as well as in nephroblastomas and neuroblastomas, multiplicity is a criterion of T classification.

8. In the case of a primary of unknown origin, staging will be based on **reasonable clinical certainty** of the primary organ.

   If **reasonable clinical certainty** is not obvious, the case *cannot be staged*. For example, if a patient has brain metastases diagnosed by a computed tomographic (CT) imaging scan, and the physician records that the primary is *probably* lung, code the primary site to lung and use the lung classification system for staging. However, if a patient is noted to have metastatic disease to the liver, and the pathology report cites that the primary may be lung or colon, this case cannot be staged, unless the origin of the primary is documented elsewhere.

9. For in-situ classification, if there is an acceptable histologic classification of in-situ carcinoma as determined by your pathologist, but it has not been specified in the AJCC chapter, it can be used to classify pTis. The correct classification for in-situ lesions is **p**Tis **c**N0 **c**M0, and should be reported as both clinical stage group 0 and pathologic stage group 0.

10. If pathologic assessment of lymph nodes reveals negative nodes but the number of examined lymph nodes is less than the suggested number for lymph node dissection, classify the N category as pN0. Only one lymph node is required to be removed for pathologic staging.

11. Isolated tumor cells (ITC's) are single tumor cells or small clusters of cells not more than 0.2 mm in greatest dimension that are usually detected by immunohistochemistry or molecular methods. Cases with ITC's in lymph nodes or at distant sites should be classified as N0 or M0, respectively. The same applies to cases with findings suggestive of tumor cells or their components by non morphologic techniques such as flow cytometry or DNA analysis. These cases should be analyzed separately and have special recording rules in the specific organ site.

12. Except where pM is positive, cM should be used along with pT and pN for calculating pathologic stage; "pM0" is not a valid concept. "MX" is not a valid category from 2010 forward. Infer status as cM0 unless known M1.

When physician and registrar disagree on correct TNM stage:

In situations in which the registrar disagrees with the TNM stage assigned by the physician, the registrar should attempt to resolve the discrepancy with the appropriate physician. It is also recommended that hospitals with ACoS approved cancer programs have these discrepancies reviewed by the Cancer Committee liaison to the registry if further resolution is needed. The physician’s TNM classification and stage group should be recorded in the cancer registry database and the "staged by" field should indicate physician. Any discussion or disagreement by the registrar and/or registry physician advisors should be recorded in text.

30940 - TNM STAGING EDITION

Field Length: 2

This field describes the edition of the *AJCC Cancer Staging Manual* used to classify the extent of disease at the time of initial diagnosis and/or first treatment.

Code	Description
00	Not staged (cases that have an AJCC staging scheme and staging was not done)
01	First Edition
02	Second Edition
03	Third Edition
04	Fourth Edition
05	Fifth Edition
06	Sixth Edition
07	Seventh Edition
88	Not Applicable (cases that do not have an AJCC staging scheme)
99	Staged, but the edition is unknown

30950 - cTNM CLASSIFICATION - T

Field Length: 4

The clinical T evaluates only the primary tumor and reflects tumor size and/or extension *prior* to the start of any therapy.

Record the clinical T value as documented by the first treating physician or the managing physician in the medical record. If the managed physician has not recorded clinical T, registrars should code this item based on the best available information, without necessarily requiring additional contact with the physician.

If the value is only one digit, record to the left and leave the remaining spaces blank. Choose the lower (less advanced) T category when there is any uncertainty. Refer to the *AJCC Cancer Staging Manual* for coding rules.

Code	Definition	Code	Definition	Code	Definition
blank	Not recorded	1B	T1b	3	T3
X	TX	1B1	T1b1	3A	T3a
0	T0	1B2	T1b2	3B	T3b
A	Ta	1C	T1c	3C	T3c
IS	Tis	1D	T1d	3D	T3d
ISPU	Tispu	2	T2	4	T4
ISPD	Tispd	2A	T2a	4A	T4a
1MI	T1mi, T1 mic	2A1	T2a1	4B	T4b
1	T1	2A2	T2a2	4C	T4c
1A	T1a	2B	T2b	4D	T4d
1A1	T1a1	2C	T2c	4E	T4e
1A2	T1a2	2D	T2d	88	Not applicable

30960 - cTNM CLASSIFICATION - N

Field Length: 4

Clinical N identifies the absence or presence of regional lymph node metastasis and describes the extent of regional node metastases *prior* to the start of any therapy.

Record the clinical N value as documented by the first treating physician or the managing physician in the medical record. If the managing physician has not recorded clinical N, registrars should code this item based on the best available information, without necessarily requiring additional contact with the physician.

If the value is only one digit, record to the left and leave the second space blank. Choose the lower (less advanced) N category when there is any uncertainty. Refer to the *AJCC Cancer Staging Manual* for coding rules.

When a primary tumor directly extends into lymph nodes, code as lymph node metastasis.

Code	Definition	Code	Definition
blank	Not recorded	1B	N1b
X	NX	1C	N1c
0	N0	2	N2
0I-	N0i-	2A	N2a
0I+	N0i+	2B	N2b
0M-	N0m-	2C	N2c
0M+	N0m+	3	N3
1MI	N1mi	3A	N3a
0A	N0a	2B	N2b
0B	N0b	3C	N3c
1	N1	4	N4
1A	N1a	88	Not applicable

30970 - cTNM CLASSIFICATION - M

Field Length: 4

Clinical M records the presence or absence of distant metastases *prior* to the start of any therapy.

Record the clinical M value as documented by the first treating physician or the managing physician in the medical record. If the managing physician has not recorded clinical M, registrars should code this item based on the best available information, without necessarily requiring additional contact with the physician.

If the value is only one digit, record to the left and leave the remaining spaces blank. Choose the lower (less advanced) M category when there is any uncertainty. Refer to the *AJCC Cancer Staging Manual* for coding rules.

Code	Definition
blank	Not recorded
X (AJCC editions 1-6 only)	MX (AJCC editions 1-6 only)
0	M0
0+	M0+
1	M1
1A	M1a
1B	M1b
1C	M1c
1D	M1d
1E	M1e
88	Not applicable

30980 - cTNM STAGE GROUP

Field Length: 4

This field identifies the anatomic extent of disease based on the T, N, and M elements known ***prior*** to the start of any therapy. Code the clinical TNM stage grouping from the cTNM classification in items 30950-30970, using the *AJCC Cancer Staging Manual.* Record '88' if the TNM staging system is not appropriate for this site/histology of cancer.

Note: For diagnoses prior to 2004, this field was used to calculate Best Stage Group. It becomes the value in Best Stage Group if the pTNM Stage Group is equal to '88' or '99', or if the pathologic descriptor indicates pre-surgical treatment was administered. After 2004, the CS derived AJCC 6th edition stage group is the Best Stage Group.

Code	Definition	Code	Definition
0	Stage 0	2B	Stage IIB
0A	Stage 0A	2C	Stage IIC
0IS	Stage 0is	3	Stage III
1	Stage I	3A	Stage IIIA
1A	Stage IA	3B	Stage IIIB
1A1	Stage IA1	3C	Stage IIIC
1A2	Stage IA2	3C1	Stage IIIC1
1B	Stage IB	3C2	Stage IIIC2
1B1	Stage IB1	4	Stage IV
1B2	Stage IB2	4A	Stage IVA
1C	Stage IC	4A1	Stage IVA1
1S	Stage IS	4A2	Stage IVA2
2	Stage II	4B	Stage IVB
2A	Stage IIA	4C	Stage IVC
2A1	Stage IIA1	OC	Occult
2A2	Stage IIA2	88	Not applicable
		99	Unknown

30990 - cTNM Descriptor

Field Length: 2

The prefix and suffix descriptors identify special cases that need separate analysis. The descriptors do not change the stage grouping. This field may not be left blank for cases diagnosed 1/1/2010 forward.

Code	Description
0	None
E	Extranodal, lymphomas only
S	Spleen, lymphomas only
M	Multiple primary tumors in a single site
ES	Extranodal and spleen involvement, lymphomas only
9	Unknown; not stated in patient record

31000 - STAGED BY - CLINICAL

Field Length: 1

This field identifies the person who clinically staged the case using AJCC TNM.

Code	Description
0	Not staged
1	Managing Physician
2	Pathologist
3	Pathologist and managing physician
4	Cancer Committee chair, cancer liaison physician, or registry physician advisor
5	Cancer registrar
6	Cancer registrar and any physician in 1, 2, or 3
7	Staging assigned at another facility
8	Case is not eligible for staging
9	Unknown; not stated in patient record

According to ACoS (from the I&R web site) only codes 1 and 3 meet the criteria for 90% physician staging for the CoC standard.

31010 - pTNM CLASSIFICATION - T

Field Length: 4

The pathologic T field evaluates the primary tumor and reflects tumor size and/or extension following the completion of surgical therapy.

Code the pathologic T as documented by the treating physician(s) or the managing physician in the medical record. If the managing physician has not recorded pathologic T, registrars should code this item based on the best available information, without necessarily requiring additional contact the physician.

If the value is only one digit, record to the left and leave the remaining spaces blank. Choose the lower (less advanced) T category when there is any uncertainty. Refer to the *AJCC Cancer Staging Manual* for coding rules.

Code	Definition	Code	Definition	Code	Definition
blank	Not recorded	1B	T1b	3	T3
X	TX	1B1	T1b1	3A	T3a
0	T0	1B2	T1b2	3B	T3b
A	Ta	1C	T1c	3C	T3c
IS	Tis	1D	T1d	3D	T3d
ISPU	Tispu	2	T2	4	T4
ISPD	Tispd	2A	T2a	4A	T4a
1MI	T1mi, T1 mic	2A1	T2a1	4B	T4b
1	T1	2A2	T2a2	4C	T4c
1A	T1a	2B	T2b	4D	T4d
1A1	T1a1	2C	T2c	4E	T4e
1A2	T1a2	2D	T2d	88	Not applicable

31020 - pTNM CLASSIFICATION - N

Field Length: 4

Pathologic N identifies the absence or presence of regional lymph nodes metastasis and describes the extent of lymph node metastases following the completion of surgical therapy.

Record the pathologic N value as documented by the treating physician or managing physician in the medical record. If the managing physician has not recorded pathologic N, registrars should code this item based on the best available information, without necessarily requiring additional contact with the physician.

If the value is only one digit, record to the left and leave the remaining spaces blank. Choose the lower (less advanced) N category when there is any uncertainty. Refer to the *AJCC Cancer Staging Manual* for coding rules.

When a primary tumor directly extends into lymph nodes, code as lymph node metastasis.

Code	Definition	Code	Definition
blank	Not recorded	1B	N1b
X	NX	1C	N1c
0	N0	2	N2
0I-	N0i-	2A	N2a
0I+	N0i+	2B	N2b
0M-	N0m-	2C	N2c
0M+	N0m+	3	N3
1MI	N1mi	3A	N3a
0A	N0a	2B	N2b
0B	N0b	3C	N3c
1	N1	4	N4
1A	N1a	88	Not applicable

31030 - pTNM CLASSIFICATION - M

Field Length: 4

Pathologic M records the presence or absence of distant metastases following the completion of surgical therapy.

Record the pathologic M value as documented by the treating physician or managing physician in the medical record. If the managing physician has not recorded pathologic M, registrars should code this item based on the best available information, without necessarily requiring additional contact with the physician.

If the value is only one digit, record it in the space to the left and leave the remaining spaces blank. Choose the lower (less advanced) M category when there is any uncertainty. Refer to the *AJCC Cancer Staging Manual* for coding rules.

Code	Definition
blank	Not recorded
X (AJCC editions 1-6 only)	MX (AJCC editions 1-6 only)
0 (AJCC editions 1-6 only)	M0 (AJCC editions 1-6 only)
1	M1
1A	M1a
1B	M1b
1C	M1c
1D	M1d
1E	M1e
88	Not applicable

31040 - pTNM STAGE GROUP

Field Length: 4

This field identifies the anatomic extent of disease based on the T, N, and M elements known ***following*** the completion of surgical therapy. Code the pathologic TNM stage grouping from the pTNM classification in items 31010-31030, using the *AJCC Cancer Staging Manual.* Record '88' if the site/histology does not have a TNM staging scheme. Choose the lower (less advanced) stage grouping when there is any uncertainty.

Note: For diagnoses prior to 2004, this field was used to calculate Best Stage Group. It becomes the Best Stage, unless the value is '88' or '99,' or pre-surgical treatment was administered. After 2004, the CS derived AJCC 6th edition stage group is the Best Stage Group.

Code	Definition	Code	Definition
0	Stage 0	2B	Stage IIB
0A	Stage 0A	2C	Stage IIC
0IS	Stage 0is	3	Stage III
1	Stage I	3A	Stage IIIA
1A	Stage IA	3B	Stage IIIB
1A1	Stage IA1	3C	Stage IIIC
1A2	Stage IA2	3C1	Stage IIIC1
1B	Stage IB	3C2	Stage IIIC2
1B1	Stage IB1	4	Stage IV
1B2	Stage IB2	4A	Stage IVA
1C	Stage IC	4A1	Stage IVA1
1S	Stage IS	4A2	Stage IVA2
2	Stage II	4B	Stage IVB
2A	Stage IIA	4C	Stage IVC
2A1	Stage IIA1	OC	Occult
2A2	Stage IIA2	88	Not applicable
		99	Unknown

31050 - pTNM Descriptor

Field Length: 2

The prefix and suffix descriptors identify special cases that need separate analysis. The descriptors do not change the stage grouping. This field may not be left blank for cases diagnosed 1/1/2010 forward.

Code	Description
0	None
E	Extranodal, lymphomas only
S	Spleen, lymphomas only
M	Multiple primary tumors in a single site
ES	Extranodal and spleen involvement, lymphomas only
Y	Staged after neoadjuvant therapy
MY	Multi synchronous tumors and staged after neoadjuvant therapy
9	Unknown; not stated in patient record

31060 - STAGED BY - PATHOLOGIC

Field Length: 1

This field identifies the person who recorded the pathologic AJCC staging elements and the stage group in the patient's medical record.

Code	Description
0	Not staged
1	Managing Physician
2	Pathologist
3	Pathologist and managing physician
4	Cancer Committee chair, cancer liaison physician, or registry physician advisor
5	Cancer registrar
6	Cancer registrar and any physician in 1, 2, or 3
7	Staging assigned at another facility
8	Case is not eligible for staging
9	Unknown; not stated in patient record

According to ACoS, on the I&R web site, only codes 1 and 3 meet the criteria for 90% physician staging for the CoC standard.

31070 - Alternate (PED) Staging System

Field Length: 2

Some institutions want to record alternate staging schemes for specified sites of malignancies. These are optional, except for pediatric cases (see below). Some alternate staging systems for specific sites are shown below:

Code	Alternate Staging System	Site/Histology
VA	VA staging scheme	lung - small cell
AW	American/Whitmore	prostate
DM	Dukes (Modified)	colon/rectum
C	Clark's levels	melanoma
JM	Jewett-Marshall	bladder
FI	FIGO	cervix uterus/endometrium ovary
AA	Ann Arbor	lymphoma in adults
RB	Rai Binet	CLL

Pediatric staging is required for pediatric cases. There is no age limit to define pediatric cases -- it is based on the type of tumor. Codes for pediatric staging systems are:

Code	Description
00	None
01	American Joint Committee on Cancer (AJCC)
02	Ann Arbor
03	Children's Cancer Group (CCSG)
04	Evans
05	General Summary
06	Intergroup Ewings
07	Intergroup Hepatoblastoma
08	Intergroup Rhabdomyosarcoma
09	International System
10	Murphy
11	National Cancer Institute (Pediatric oncology)

12	National Wilms' Tumor Study
13	Pediatric Oncology Group (POG)
14	Reese-Ellsworth
15	SEER Extent of Disease
97	Other
98	Not applicable
99	Unknown

31080 - Alternate (PED) Stage

Field Length: 3

When an alternate staging system is designated in Item 31070, enter the alternate stage as defined by that staging system in this element. The field can contain up to three characters and should be left-justified. Always use ARABIC numerals instead of ROMAN numerals.

EXAMPLES:

FIGO Stage	IIB should be coded 2B
DUKE'S Stage	Cl should be coded Cl
Pediatric Staging	IIID (for Wilms' Tumors) should be 3D IVS (for neuroblastomas) should be 4S
VA Staging	L = limited; E = extended

Leave blank if not applicable.

31090 - MANAGING PHYSICIAN

Field Length: 7
(effective 1/1/2007)

This field is provided to record the code number of the physician who is managing this patient's care at your institution.

Coding Instructions:

- Enter the code number assigned to the physician managing this patient for treatment at your institution. Use the physician's Kentucky Medical License Number or codes developed by your institution (for non-KY physicians) to record physicians involved with this case. The web site for the Kentucky Board of Medical Licensure is located at: http://kbml.ky.gov/. The link for the online directory is found under Online Searches, called Physician Profile/Verification of Physician License. A lookup for NPI numbers is available at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.
- **Do not update this item**. Once a managing physician has been designated for this patient, this item should not be changed even if a different managing physician is assigned.
- This field may be left blank for cases diagnosed prior to 1/1/2007.

31130 - PRIMARY SURGEON

Field Length: 7

The primary surgeon is responsible for the surgical management of the patient's malignancy. Record the code which identifies the surgeon who performed the most definitive surgical procedure. If definitive surgery was not performed, record the code which identifies the surgeon who performed any non-definitive surgical procedure. If no surgery was performed, code '0000000'. If a surgical procedure was performed by someone other than a surgeon (i.e., a radiation oncologist), code '8888888'.

Use the Kentucky Medical License number or your own codes developed for identifying physicians. The web site for the Kentucky Board of Medical Licensure is located at: http://kbml.ky.gov/. The link for the online directory is found under Online Searches, called Physician Profile/Verification of Physician License.

A lookup for NPI numbers is available at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

Once the registrar has identified the primary surgeon, this code should not be changed, even if the patient begins receiving care from another physician.

31131 - Radiation Oncologist

Field Length: 7

This field is provided to record the code number of the physician who performed the most definitive radiation therapy.

Coding Instructions:

- Enter the code number assigned to the primary radiation oncologist. Use the physician's Kentucky Medical License Number or codes developed by your institution (for non-KY physicians) to record physicians involved with this case. The web site for the Kentucky Board of Medical Licensure is located at: http://kbml.ky.gov/. The link for the online directory is found under Online Searches, called Physician Profile/Verification of Physician License. A lookup for NPI numbers is available at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.
- **Do not update this item**. Once a radiation oncologist has been designated for this patient, this item should not be changed even if the patient receives care from another radiation oncologist.

31132 - Medical Oncologist

Field Length: 7

This field is provided to record the code number of the physician who performed the most definitive systemic therapy.

Coding Instructions:

- Enter the code number assigned to the primary medical oncologist. Use the physician's Kentucky Medical License Number or codes developed by your institution (for non-KY physicians) to record physicians involved with this case. The web site for the Kentucky Board of Medical Licensure is located at: http://kbml.ky.gov/. The link for the online directory is found under Online Searches, called Physician Profile/Verification of Physician License. A lookup for NPI numbers is available at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.
- **Do not update this item**. Once a medical oncologist has been designated for this patient, this item should not be changed even if the patient receives care from another medical oncologist.

31140 - ABSTRACTED BY

Field Length: 2

Record the initials or a two-digit code which identifies the person in your facility who abstracted this case.

31150 - ACOS CODING SYSTEM - ORIGINAL

Field Length: 1

Record the one-digit code which identifies the coding scheme of the American College of Surgeons used when originally abstracting this case.

Code	Description
0	No Commission on Cancer coding system used
1	Pre-1988 (Cancer Program Manual Supplement)
2	1988 Data Acquisition Manual
3	1989 Data Acquisition Manual Revisions
4	1990 Data Acquisition Manual Revisions
5	1994 Data Acquisition Manual (Interim/Revised)
6	Registry Operations and Data Standards (ROADS)
7	1998 ROADS Revisions
8	FORDS Manual
9	Unknown

This data element was introduced with the ROADS manual and effective January 1, 1996. All cases with accession years prior to 1996 should be coded '9'. All cases accessioned from January 1, 1996 to December 31, 1997 should be coded '6'.

Cases abstracted and entered using the ROADS Manual should be coded '7'. Cases abstracted and entered using the FORDS Manual coding instructions should be coded '8'.

31160 - ACOS CODING SYSTEM - CURRENT

Field Length: 1

Record the one-digit code to identify the coding scheme of the American College of Surgeons in which the data are currently stored.

This data element was introduced with the ROADS manual revisions effective January 1, 1998. All previously entered cases have been converted and are currently stored according to the specifications of the FORDS Manual, (Code 8).

Cases diagnosed from January 1, 2003 and after should be coded '8' for FORDS manual.

31170 - TYPE OF REPORTING SOURCE

Field Length: 1

The Type of Reporting Source identifies the source documents used to abstract the case. This is not necessarily the original document that identified the case; rather, it is the source that provided the best information.

Code	Description
1	Hospital inpatient; Managed health plans with comprehensive, unified medical records (new code definition effective with diagnosis on or after 1/1/2006)
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent) (effective with diagnosis on or after 1/1/2006)
3	Laboratory only (hospital-affiliated or independent)
4	Physician's Office/Private Medical Practitioner (LMD)
5	Nursing/Convalescent Home/Hospice
6	Autopsy only
7	Death Certificate only
8	Other hospital outpatient units/surgery centers (effective with diagnosis on or after 1/1/2006)

Definitions

Managed health plan: HMO or other health plan (e.g. Kaiser, Veterans Administration, military facilities) in which all diagnostic and treatment information is maintained centrally (in a unit record) and is available to the abstractor.

Physician office: Examinations, tests and limited surgical procedures may be performed in a physician office. If called a surgery center, but cannot perform surgical procedures under general anesthesia, code as a physician office.

Serial record: The office or facility stores information separately for each patient encounter.

Surgery center: Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. Patient does not stay overnight.

Unit record: The office or facility stores information for all of a patient's encounters in one record with one record number.

Priority Order for Assigning Type of Reporting Source

When multiple source documents are used to abstract a case, use the following priority order to assign a code for Type of Reporting Source:

Priority order of codes
1, 2, 8, 4, 3, 5, 6, 7

Note: Beginning with cases diagnosed 1/1/2006, the definitions for this field have been expanded. Codes 2 and 8 were added to identify outpatient sources that were previously grouped under code 1. Laboratory reports now have priority over nursing home reports. The source facilities included in the previous code 1 (hospital inpatient and outpatient) are split between codes 1, 2, and 8. No changes were made to the field for cases already existing in the cancer registry database diagnosed prior to January 1, 2006.

Code Definitions

Code	Label	Source Documents	Priority
1	Hospital inpatient: Managed health plans with comprehensive, unified medical records	-Hospital inpatient -Offices/facilities with unit record -HMO physician office or group -HMO affiliated free-standing laboratory, surgery, radiation or oncology clinic Includes outpatient services of HMOs and large multi-specialty physician group practices with unit record.	1
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)	-Facilities with serial record (not a unit record) -Radiation treatment centers -Medical oncology centers (hospital affiliated or independent) There were no source documents from code 1.	2

3	Laboratory Only (hospital-affiliated or independent)	-Laboratory with serial record (not a unit record) There were no source documents from codes 1, 2, 8, or 4.	5
4	Physician’s Office/Private Medical Practitioner (LMD)	-Physician’s office that is NOT an HMO or large multi-specialty physician group practice. There were no source documents from codes 1, 2, or 8.	4
5	Nursing/Convalescent Home/ Hospice	-Nursing or convalescent home or a hospice. There were no source documents from codes 1, 2, 8, 4, or 3.	6
6	Autopsy Only	-Autopsy The cancer was first diagnosed on autopsy. There are no source documents from codes 1, 2, 8, 4, 3, or 5.	7
7	Death Certificate Only	-Death Certificate Death Certificate is the only source of information; follow-back activities did not identify source documents from codes 1, 2, 8, 4, 3, 5, or 6. If another source document is subsequently identified, the Type of Reporting Source code must be changed to the appropriate code in the range of 1, 2, 8, 4, 3, or 6.	8
8	Other hospital outpatient units/surgery centers	-Other hospital outpatient units/surgery centers. Includes, but not limited to, outpatient surgery and nuclear medicine services. There are no source documents from codes 1 or 2.	3

31175 - REASON NO NON-DEFINITIVE SURGERY

Field Length: 1

This item records the reason no non-definitive surgical procedure was performed as part of the initial diagnostic work up. If non-definitive surgery was performed and the pathology specimen was diagnostic of malignancy (code 1), a non-definitive surgical therapy record **must** be created for the earliest positive non-definitive surgical procedure.

NOTE: For this field, record only biopsies which obtain tissue (whether positive or negative for malignancy). Fine needle aspirations (which obtain only cells, not tissue) of the primary tumor or of a metastatic site are **not** recorded, whether positive or negative. FNA's of regional lymph nodes are recorded as surgical therapies, in the item "Scope of Regional Lymph Node Surgery). Please see item #50090 for further instruction regarding non-definitive surgery.

Code	Description
0	Non-definitive surgery not performed; not applicable; or not recommended for this case. Autopsy only.
1	Non-definitive surgery performed and results diagnostic of malignancy
2	Non-definitive surgery performed but results negative
3	Non-definitive surgery performed and results turned out to be definitive tx (excisional bx)
8	No non-definitive surgery at this hospital, unknown if done elsewhere
9	Unknown if non-definitive surgery performed

31180 - REASON NO SURGERY AT PRIMARY SITE

Field Length: 1

Using the codes below, record the reason there was no cancer-directed Surgery of the Primary Site as ***part of first course treatment***.

Code	Description
0	**Surgery performed**. Surgery of the Primary Site is coded 10-90.
1	**Surgery not performed** because not part of planned 1st course therapy. Assign code 1 when: a. There is no information in the patient's medical record about surgery AND i. It is known that surgery is not usually performed for this type and/or stage of cancer OR ii. There is no reason to suspect that the patient would have had surgery. iii. Reason No Surgery must be coded '1' when the primary site is C42.0, C42.1, C42.3, C42.4, C76.0-C76.8, C80.9 OR when the histology code is one of these: 9750, 9760-9764, 9800-9820, 9826, 9831-9897, 9910-9920, 9931-9964, or 9980-9989. b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include surgery, or if the option of no treatment was accepted by the patient. c. Patient elects to pursue no treatment following the discussion of surgery treatment. Discussion does not equal a recommendation. d. Only information available is that the patient was referred to a surgeon. Referral does not equal a recommendation. e. Watchful waiting (prostate) is the treatment plan.
2	**Surgery not recommended or performed contraindicated due to patient risk factors** (age, comorbid condition, etc).
5	**Surgery planned** but patient died prior to treatment.
6	**Reason unknown for no surgery**. Surgery would have been the treatment of choice, but no surgery was performed and the reason is not given.
7	**Patient or patient's guardian refused surgery**.
8	**Surgery recommended, unknown if done.**
9	**Unknown if surgery recommended or performed,** diagnosed at autopsy or death certificate only cases.

31190 - REASON NO THERAPY TYPE: CHEMOTHERAPY

Field Length: 1

Using the codes below, record the reason there was no chemotherapy administered as part of first course treatment.

Code	Description
0	Chemotherapy was not administered because it was not part of the planned first course treatment. Use code 0 when: a. There is no information in the patient's medical record about chemotherapy AND i. It is known that chemotherapy is not usually performed for this type and/or stage of cancer OR ii. There is no reason to suspect that the patient would have had chemotherapy. b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include chemotherapy, or if the option of no treatment was accepted by the patient. c. Patient elects to pursue no treatment following the discussion of chemotherapy treatment. Discussion does not equal a recommendation. d. Only information available is that the patient was referred to an oncologist. Referral does not equal a recommendation. e. Watchful waiting is the planned course of treatment. f. Patient was diagnosed at autopsy.
1	Chemotherapy was administered.
2	Chemotherapy was not recommended/administered because it was contraindicated due to other patient risk factors (comorbid conditions, advanced age, etc.).
5	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
6	Chemotherapy was not administered; it was recommended by the patient's physician, but was not administered as part of first course treatment. No reason was noted in patient record.
7	Chemotherapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Chemotherapy was recommended, but it is unknown whether it was administered.
9	It is unknown if chemotherapy was recommended or administered, or death certificate only cases.

31200 - REASON NO THERAPY TYPE: RADIATION

Field Length: 1

Using the codes below, record the reason there was no radiotherapy administered as part of first course treatment.

Code	Description
0	Radiation therapy was not administered because it was not part of the planned first course treatment. Use code 0 when: a. There is no information in the patient's medical record about radiation AND i. It is known that radiation is not usually performed for this type and/or stage of cancer OR ii. There is no reason to suspect that the patient would have had radiation. b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include radiation, or if the option of no treatment was accepted by the patient. c. Patient elects to pursue no treatment following the discussion of radiation treatment. Discussion does not equal a recommendation. d. Only information available is that the patient was referred to a radiation oncologist. Referral does not equal a recommendation. e. Watchful waiting (prostate). f. If diagnosed at autopsy
1	Radiation therapy was administered.
2	Radiation therapy was not recommended/administered because it was contraindicated due to other patient risk factors (comorbid conditions, advanced age, etc.).
5	Radiation therapy was not administered because the patient died prior to planned or recommended therapy.
6	Radiation therapy was not administered; it was recommended by the patient's physician, but was not administered as part of first course treatment. No reason was noted in patient record.
7	Radiation therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Radiation therapy was recommended, but it is unknown whether it was administered.
9	It is unknown if radiation therapy was recommended or administered. Death certificate and autopsy cases only.

31210 - REASON NO THERAPY TYPE: HORMONE

Field Length: 1

Using the codes below, record the reason there was no hormone therapy administered as part of first course treatment.

Code	Description
0	Hormone therapy was not administered because it was not part of the planned first course treatment. Use code 0 when: a. There is no information in the patient's medical record about hormone therapy AND i. It is known that hormone therapy is not usually performed for this type and/or stage of cancer OR ii. There is no reason to suspect that the patient would have had hormone treatment. b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include hormone therapy, or if the option of no treatment was accepted by the patient. c. Patient elects to pursue no treatment following the discussion of hormone treatment. Discussion does not equal a recommendation. d. Only information available is that the patient was referred to an oncologist. Referral does not equal a recommendation. e. Watchful waiting is the only planned treatment. f. Patient was diagnosed at autopsy.
1	Hormone therapy was administered.
2	Hormone therapy was not recommended/administered because it was contraindicated due to other patient risk factors (comorbid conditions, advanced age, etc.).
5	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
6	Hormone therapy was not administered; it was recommended by the patient's physician, but was not administered as part of first course treatment. No reason was noted in patient record.
7	Hormone therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Hormone therapy was recommended, but it is unknown whether it was administered.
9	It is unknown if hormone therapy was recommended or administered. Death certificate only cases.

31220 - REASON NO THERAPY TYPE: IMMUNOTHERAPY

Field Length: 1

Using the codes below, record the reason there was no immunotherapy administered as part of first course treatment.

Code	Description
0	Immunotherapy was not administered because it was not part of the planned first course treatment. Use code 0 when: a. There is no information in the patient's medical record about immunotherapy AND i. It is known that immunotherapy is not usually performed for this type and/or stage of cancer OR ii. There is no reason to suspect that the patient would have had immunotherapy. b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include immunotherapy, or if the option of no treatment was accepted by the patient. c. Patient elects to pursue no treatment following the discussion of immunotherapy. Discussion does not equal a recommendation. d. Only information available is that the patient was referred to an oncologist. Referral does not equal a recommendation. e. Watchful waiting is the only planned treatment. f. Patient was diagnosed at autopsy.
1	Immunotherapy was administered.
2	Immunotherapy was not recommended/administered because it was contraindicated due to other patient risk factors (comorbid conditions, advanced age, etc.).
5	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
6	Immunotherapy was not administered; it was recommended by the patient's physician, but was not administered as part of first course treatment. No reason was noted in patient record.
7	Immunotherapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Immunotherapy was recommended, but it is unknown whether it was administered.
9	It is unknown if immunotherapy was recommended or administered, or death certificate only cases.

31230 - REASON NO TRANSPLANT/ENDOCRINE PROCEDURES

Field Length: 1

Using the codes below, record the reason there was no transplant or endocrine procedures administered as part of first course treatment.

Code	Description
0	This therapy type was not administered because it was not part of the planned first course treatment. Use code 0 when: a. There is no information in the patient's medical record about transplants or endocrine surgery AND i. It is known that these procedures are not usually performed for this type and/or stage of cancer OR ii. There is no reason to suspect that the patient would have had these procedures. b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include transplant or endocrine surgery, or if the option of no treatment was accepted by the patient. c. Patient elects to pursue no treatment following the discussion of transplant or endocrine procedures. Discussion does not equal a recommendation. d. Only information available is that the patient was referred to a transplant or endocrine surgeon. Referral does not equal a recommendation. e. Watchful waiting is the only planned treatment. f. Patient was diagnosed at autopsy.
1	This therapy type was administered.
2	This therapy type was not recommended/administered because it was contraindicated due to other patient risk factors (comorbid conditions, advanced age, etc.)
5	This therapy type was not administered because the patient died prior to planned or recommended therapy.
6	This therapy type was not administered; it was recommended by the patient's physician, but was not administered as part of first course treatment. No reason was noted in patient record.
7	This therapy type was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	This therapy type was recommended, but it is unknown whether it was administered.
9	It is unknown if this therapy type was recommended or administered. Death certificate only cases.

31240 - REASON NO THERAPY TYPE: OTHER THERAPY

Field Length: 1

Using the codes below, record the reason there was no other therapy administered as part of first course treatment.

Code	Description
0	Other therapy was not administered because it was not part of the planned first course treatment. Use code 0 when: a. There is no information in the patient's medical record about other therapy AND i. It is known that other therapy is not usually performed for this type and/or stage of cancer OR ii. There is no reason to suspect that the patient would have had other therapy. b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include these other therapies. c. Patient elects to pursue no treatment following the discussion of other types of treatment. Discussion does not equal a recommendation. d. Only information available is that the patient was referred to an oncologist. Referral does not equal a recommendation. e. Watchful waiting is the only planned treatment. f. Patient was diagnosed at autopsy.
1	Other therapy was administered.
2	Other therapy was not recommended/administered because it was contraindicated due to other patient risk factors (comorbid conditions, advanced age, etc.).
5	Other therapy was not administered because the patient died prior to planned or recommended therapy.
6	Other therapy was not administered; it was recommended by the patient's physician, but was not administered as part of first course treatment. No reason was noted in patient record.
7	Other therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Other therapy was recommended, but it is unknown whether it was administered.
9	It is unknown if other therapy was recommended or administered. Death certificate only cases.

31245 - Treatment Follow-back Needed

Field length: 1

Code	Description
0	No
1	Yes

31250 - Systemic Therapy/Surgery Sequence

Field Length: 1

This field only applies to cases diagnosed on or after January 1, 2006. It records the sequence of systemic therapy and surgical procedures given as part of first course treatment. Systemic therapy includes any chemotherapy, hormone therapy, immunotherapy, transplants or endocrine surgeries. Surgical procedures include any surgery at the primary site, surgery of regional lymph nodes, or surgery at other regional or distant sites. It does not include non-definitive surgeries such as incisional biopsies or bypass surgeries.

Code the administration of systemic therapy in sequence with the **first** surgery performed. The sequence of systemic therapy and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. If the systemic therapy and surgery were administered on the same day, any code 2-9 could be appropriate. If there was no systemic therapy given or no definitive surgery performed, or if it unknown whether the patient received both surgery and systemic therapy, then code '0'. Code 0 for DCO cases.

Code	Label	Definition
0	No systemic therapy and/or surgical procedures	No systemic therapy was given; and/or no surgical procedure of primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s); or no reconstructive surgery was performed, or it is unknown whether both surgery and systemic treatment were provided; or case diagnosed at autopsy.
2	Systemic therapy before surgery	Systemic therapy was given before surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
3	Systemic therapy after surgery	Systemic therapy was given after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
4	Systemic therapy both before and after surgery	Systemic therapy was given before and after any surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.

5	Intraoperative systemic therapy	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative systemic therapy with other therapy administered before or after surgery	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) with other systemic therapy administered before or after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
7	Surgery both before and after systemic therapy	Systemic therapy was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	Sequence unknown	Both surgery and systemic therapy were provided, but the sequence of treatments not stated or unknown; or death certificate only case.

31251 - Radiation/Surgery Sequence

Field Length: 1

For cases diagnosed prior to January 1, 2010, this field is automatically calculated by CPDMS.net.

This field records the sequencing of radiation and surgical procedures given as part of the first course of treatment. Surgical procedures include Surgical Procedure at Primary Site, Scope of Regional Lymph Node Surgery, and Surgical Procedure/Other Site. If no surgical procedures were performed, or if it is not known whether the patient received both surgery and radiation, this item should be coded 0. Code 0 for DCO cases.

Code	Label	Definition
0	No radiation therapy and/or surgical procedures	No radiation therapy given or unknown if radiation therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s), or it is unknown whether any surgery given.
2	Radiation therapy before surgery	Radiation therapy given before surgery to primary site, regional lymph node surgery, or surgery to other regional site(s), distant site(s), or distant lymph node(s).
3	Radiation therapy after surgery	Radiation therapy given after surgery to primary site, regional lymph node surgery, or surgery to other regional site(s), distant site(s), or distant lymph node(s).
4	Radiation therapy both before and after surgery	Radiation therapy given before and after any surgery to primary site, regional lymph node surgery, or surgery to other regional site(s), distant site(s), or distant lymph node(s).
5	Intraoperative radiation therapy	Intraoperative radiation therapy was administered during surgery to primary site, regional lymph node surgery, or surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative radiation therapy with other radiation therapy administered before or after surgery	Intraoperative radiation therapy given during surgery to primary site, regional lymph node surgery, or surgery to other regional site(s), distant site(s), or distant lymph node(s) with other radiation therapy administered before or after surgery to primary site, regional lymph node surgery, or surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	Sequence unknown	Administration of radiation therapy and surgery to primary site, regional lymph node surgery, or surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed but the sequence of the treatment is not stated in the patient record.

31255 - TREATMENT STATUS

Field Length: 1

This data item summarizes whether the patient received any treatment or if the tumor was under active surveillance. It is mandatory for cases diagnosed January 1, 2010 onward, but may be left blank for case diagnosed prior to 2010.

Treatment given after a period of active surveillance is considered subsequent treatment and is not coded in this item.

Code	Description
0	No treatment given
1	Treatment given
2	Active surveillance (watchful waiting)
9	Unknown if treatment was given

Examples

Code	Reason
0	An elderly patient with pancreatic cancer requested no treatment.
0	Patient is expected to receive radiation, but it has not occurred yet.
2	Treatment plan for a lymphoma patient is active surveillance.

Coding Instructions

1. Assign code 1 when the patient receives treatment collected in any of the following fields

    a. Surgery of primary site

    b. Scope of regional lymph node surgery

    c. Surgical procedure of other site

    d. Radiation

    e. Chemotherapy

    f. Hormone therapy

g. Immunotherapy

h. Hematologic transplant and endocrine procedures

i. Other therapy

2. Assign code 9 for death certificate only (DCO) cases

3. Leave blank for cases diagnosed prior to January 1, 2010

31260 - DATE NO FIRST THERAPY

Field Length: 8

This field should be filled in when the calculated Treatment Start Date (ACoS) is blank.

If the physician decides not to treat the patient, record the date of this decision as Date No First Therapy. If the patient or guardian refuses treatment, record the date of this decision. For autopsy only cases, record the date of death. If the patient was diagnosed at the reporting facility and no further information is available, record the date the patient was last seen at the reporting facility. Code '99999999' when it is unknown if any treatment was given, or if the date cannot be reasonably estimated.

This means no first course definitive treatment of any type was administered to any site (primary, regional or distant).

31270 - Treatment Start Date (ACoS)

Field Length: 8

The treatment start date is a case level data item that is calculated by the computer for all records that are entered as a full Abstract Form. It is the date of the initiation of first course definitive therapy for this cancer. The calculation reviews all treatment types except N, including surgeries at regional and distant sites, to determine the earliest start date. **If there was no definitive first course therapy recorded, this field will be blank.** If the Treatment Start Date = <blank>, then the Date of No First Therapy **must** be filled in.

31280 - First Treatment Composite Code

Field Length: 2

The treatment composite code is a case level data item that will allow you to select and analyze groups of patients based on the therapy they received.

This code will be calculated from the therapy records marked First Course that are stored for the case, and the codes will be defined as they are for the Therapy Report. Surgeries at regional and distant sites **will not be considered** surgical treatment for this calculation.

Code	Description
00	No Definitive Therapy or Surgery at Regional and/or Distant Sites only
01	Surgery at Primary Site Only
02	Chemotherapy Only
03	Surgery at Primary Site/Chemotherapy
04	Radiation Therapy Only
05	Surgery at Primary Site/Radiation Therapy
06	Chemotherapy/Radiation Therapy
07	Surgery at Primary Site/Chemo/Radiation Therapy
08	Other Therapy Only
09	Surgery at Primary Site/Other Therapy
10	Chemotherapy/Other Therapy
11	Surgery at Primary Site/Chemo/Other Therapy
12	Radiation/Other Therapy
13	Surgery at Primary Site/Radiation/Other Therapy
14	Chemo/Radiation/Other Therapy
15	Surgery at Primary Site/Chemo/Radiation/Other Therapy
64	Unknown if or what therapy received.

31290 - All Treatment Composite Code

Field Length: 2

The treatment composite code is a case level data item that will allow you to select and analyze groups of patients based on the therapy they received.

This code will be calculated from the all therapy records **(First and Subsequent Course)** that are stored for the case, and the codes will be defined as they are for the Therapy Report. Surgeries at regional and distant sites **will not be considered** surgical treatment for this calculation.

Code	Description
00	No Definitive Therapy or Surgery at Regional and/or Distant Sites only
01	Surgery at Primary Site Only
02	Chemotherapy Only
03	Surgery at Primary Site/Chemotherapy
04	Radiation Therapy Only
05	Surgery at Primary Site/Radiation Therapy
06	Chemotherapy/Radiation Therapy
07	Surgery at Primary Site/Chemo/Radiation Therapy
08	Other Therapy Only
09	Surgery at Primary Site/Other Therapy
10	Chemotherapy/Other Therapy
11	Surgery at Primary Site/Chemo/Other Therapy
12	Radiation/Other Therapy
13	Surgery at Primary Site/Radiation/Other Therapy
14	Chemo/Radiation/Other Therapy
15	Surgery at Primary Site/Chemo/Radiation/Other Therapy

64	Unknown if or what therapy received.

31300 - QA Review Status

Field Length: 1

Record the one digit code for the type of coding review performed on this abstract.

Code	Description
1	Physician reviewed abstract
2	Registrar reviewed abstract
3	User defined
4	User defined
5	User defined
6	User defined

31310 - Central Review Status

Field Length: 1

This field is reserved for KCR use only. It is used to monitor the number and type of reviews performed by KCR staff. Record the one digit code for the type of coding review performed on this abstract.

Code	Description
1	Complete review of abstract
2	Selected fields reviewed
3	Case selected for re-abstracting audit
4	Both complete review and selected for audit
5	Both selected fields reviewed and selected for audit
6	Selected and reviewed for special study
7	Selected for a special study and any other type of review

31320 - Vendor

Field Length: 10

This field records the name of the vendor which programmed the software used by the registry. It may be abbreviated as necessary and may include the software version number where available. The code is self-assigned by the vendor.

This field does not appear in the abstract and is not available for data analysis, but is included in NAACCR format export files. It will be automatically populated in records stored and exported by CPDMS.net.

31340 - Census Tract 1970/80/90

Field Length: 6

For cases diagnosed prior to 1998, the census tract 1970/80/90 code identifies the patient's usual residence when the tumor was diagnosed. The central registry calculates this code from the patient's address at diagnosis. This field is available only in the KCR central registry database and is considered a confidential field.

A census tract is a small statistical subdivision of a county. Census tract codes originate from the U.S. Census Bureau, and are constructed using the patient's address. Codes are available from state health departments or the U.S. Census Bureau. Census tracts change as the population changes.

To interpret census tract, assume that the decimal point is between the fourth and fifth positions of the field. Add zeros to fill all six positions.

EXAMPLE: Census tract 409.6 would be coded 040960, and census tract 516.21 would be coded 051621.

Special codes:

Code	Description
000000	Area is not census tracted
999999	Area is census tracted, but census tract is not available

31350 - Census Tract Coding System

Field Length: 1

A census tract is a small statistical subdivision of a county with (generally) between 2,500 and 8,000 residents. The boundaries of census tracts are established cooperatively by local committees and the Census Bureau. An attempt is made to keep the same boundaries from census to census so that historical comparability will be maintained. This goal is not always achieved; old tracts may be subdivided due to population growth, disappear entirely, or have their boundaries changed. The census tract definition used to code the case's census tract field must be recorded so that data are correctly grouped and analyzed.

Codes	Description
0	Not tracted
1	1970 Census Tract Definition
2	1980 Census Tract Defintion
3	1990 Census Tract Definition (1988 + diagnoses)
4	2000 Census Tract Definitions (2000 + diagnoses)

31370 - Census Tract 2000

Field Length: 6

This field records the census tract of a patient's residence at the time of diagnosis, using codes from the Year 2000 Census conducted by the U.S. Census Bureau. The central registry calculates this code from the patient's address at diagnosis using geocoding software. This field is available only in the KCR central registry database and is considered a confidential field.

Census tract codes allow central registries to calculate incidence rates for geographical areas having population estimates. The Census Bureau provides population data for census tracts. Those rates can be used for general surveillance or special geographical and socioeconomic analysis.

Code	Description
000100-999998	Census tract codes
000000	Area not census tracted
999999	Area census tracted, but census tract not available
blank	Census tract 2000 not coded

31380 - Census Tract Certainty 2000

Field Length: 1

This code indicates the basis of assignment of census tract for an individual record. It is helpful in identifying cases tracted from incomplete information or P.O. Boxes. This information is provided by the geocoding vendor service used by the central registry. Codes are hierarchical, with lower numbers having priority.

Code	Description
1	Census tract based on complete and valid street address of residence
2	Census tract based on residence ZIP + 4
3	Census tract based on residence ZIP + 2
4	Census tract based on residence ZIP code only
5	Census tract based on ZIP code of P.O. Box
6	Census tract based on residence city where city has only one census tract, or based on residence ZIP code where ZIP code has only one census tract
9	Unable to assign census tract or bloc numbering based on available information
blank	Not applicable (e.g., census coding not attempted)

31381 - Census Tract 2010

Field Length: 6

This field is provided for coding census tract of patient's residence at time of diagnosis. Codes are those used by the U.S. Census Bureau for the Year 2010 Census. Census tract codes have a 4-digit basic number and also may have a 2-digit suffix. Census tract numbers range from 0001.00 to 9999.98.

The Census Bureau provides population data for census tracts. Those rates can be used for general surveillance or special geographical and socioeconomic analysis.

Because census tracts for particular cases can change between censuses, the central registry may wish to assign an alternate census tract code to its cases. For example, a registry may code its 2005 cases using both the 2000 and 2010 census tract boundaries. The central registry can use this information for different comparisons.

Code	Description
000100-999998	Census tract codes
000000	Area not census tracted
999999	Area census tracted, but census tract not available
blank	Census tract 2010 not coded

31382 - Census Block Group 2010

Field Length: 1

Description
This field is provided for coding the block group of patient's residence at time of diagnosis, as defined by the 2010 Census.

Rationale
A block group is a subdivision of a census tract designed to have an average of 1500 people, versus a census tract's average of 4500 people. All land area in the United States is described by a census block group in the 2010 Census. The Census Bureau publishes detailed population and socioeconomic data at this level. Block groups thus offer a high level of specificity for geographical and socioeconomic analyses.

A block group has no meaning in the absence of a census tract. Refer to Census Tract Certainty 2010 to ascertain basis of assignment of Census Block Group 2010.

Comment
Numerous registries find the distinction between "attempted, could not be determined" (zero) and "not coded" (blank) to be useful for geocoding planning purposes.
Note: The values 1 through 9 are nominal, with no hierarchy of values. This number determines the first digit of all the blocks which comprise the block group; for instance, census block group 3 would contain blocks numbered 3000 to 3999.

Code	Description
0	Census block group assignment was attempted, but the value could not be determined
1-9	Census block group values as defined by the Census Bureau
Blank	Census Block Group 2010 not coded

31383 - Census Tract Certainty 2010

Field Length: 1

Description
Code indicating basis of assignment of census tract for an individual record. Helpful in identifying cases tracted from incomplete information or P.O. Box. This item is not coded by the hospital. Central registry staff assign the code.

Code	Description
1	Census tract based on complete and valid street address of residence
2	Census tract based on residence ZIP + 4
3	Census tract based on residence ZIP + 2
4	Census tract based on residence ZIP code only
5	Census tract based on ZIP code of P.O. Box
6	Census tract/BNA based on residence city where city has only one census tract, or based on residence ZIP code where ZIP code has only one census tract
9	Not assigned, geocoding attempted
blank	Not assigned, geocoding not attempted

31390 - Latitude

Field Length: 10

Cancer registry spatial data for a case record represents the point location of the individual's residence on the Earth's surface, expressed as a coordinate pair of latitude and longitude values. These values, which are provided by a geocoding vendor, may be determined by any one of several methods: geocoding, address matching, GPS readings, and interpolation from paper or electronic maps. This field is available only in the KCR central registry database and is considered a confidential field.

Codes

Latitude and longitude data shall always be stored and exchanged as numeric values. Latitude north of the equator is positive. Longitude west of 0 degrees (the Prime Meridian) and east of 180 (approximately the International Date Line) is negative. This applies to the entirety of North America with the exception of the tip of the Aleutian Islands in Alaska.

Latitude is a 10-byte numeric field, right justified. This coordinate may be carried out to 6 decimal places with an explicit decimal point. It has the following format: x12.345678, where 'x' is reserved for a negative sign of the coordinate represents a location south of the equator.

Spatial data are exchanged in "unprojected" latitude and longitude coordinates. The data units will be in decimal degrees (not in degrees, minutes, seconds).

Correct: Latitude = 41.890833
Incorrect: Latitude = 41 deg 53' 27"

31400 - Longitude

Field Length: 11

Cancer registry spatial data for a case record represents the point location of the individual's residence on the Earth's surface, expressed as a coordinate pair of latitude and longitude values. These values, which are provided by a geocoding vendor, may be determined by any one of several methods: geocoding, address matching, GPS readings, and interpolation from paper or electronic maps. This field is available only in the KCR central registry database and is considered a confidential field.

Codes

Latitude and longitude data shall always be stored and exchanged as numeric values. Latitude north of the equator is positive. Longitude west of 0 degrees (the Prime Meridian) and east of 180 (approximately the International Date Line) is negative. This applies to the entirety of North America with the exception of the tip of the Aleutian Islands in Alaska.

Longitude is an 11-byte numeric field, right justified. This coordinate may be carried out to 6 decimal places with an explicit decimal point. It has the following format: x123.456789, where 'x' is reserved for a negative sign of the coordinate represents a location west of 0 degrees and east of 180 degrees.

Spatial data are exchanged in "unprojected" latitude and longitude coordinates. The data units will be in decimal degrees (not in degrees, minutes, seconds).

Correct: Longitude = -123.128943
Incorrect: Longitude = -123 deg 7' 44"

31401 - GIS Coordinate Quality

Description
Code indicating the basis of assignment of latitude and longitude coordinates for an individual record from an address. This data item is helpful in identifying cases that were assigned coordinates based on incomplete information, post office boxes, or rural routes. This item is coded at the central registry, not by the reporting facility. Most of the time, this information is provided by geocoding software. Alternatively, a central registry staff member manually assigns the code. Codes are hierarchical, with lower numbers having priority.

Rationale
Spatial analysis of cancer data often requires identifying data records with a high degree of geographic precision. Researchers can use this code as a basis for selecting records with a degree of precision that is appropriate to the study.

Instructions for Coding: Where multiple codes are applicable, use the lower code value. Note: This data item is similar in function to Census Tract Certainty 1970/80/90 [364] and Census Tract Certainty 2000 [365]. The codes for this data item and the two census tract data items all describe how location information was assigned based on the patient's resident address at the time of diagnosis.

This data item must be populated if Latitude [31390] and Longitude [31400] are also populated.

Code	Description
00	Coordinates derived from local government-maintained address points, which are based on property parcel locations, not interpolation over a street segment's address range
01	Coordinates assigned by Global Positioning System (GPS)
02	Coordinates are match of house number and street, and based on property parcel location
03	Coordinates are match of house number and street, interpolated over the matching street segment's address range
04	Coordinates are street intersections
05	Coordinates are at mid-point of street segment (missing or invalid building number)
06	Coordinates are address ZIP code+4 centroid
07	Coordinates are address ZIP code+2 centroid
08	Coordinates were obtained manually by looking up a location on a paper or electronic map
09	Coordinates are address 5-digit ZIP code centroid
10	Coordinates are point ZIP code of Post Office Box or Rural Route
11	Coordinates are centroid of address city (when address ZIP code is unknown or invalid, and there are multiple ZIP codes for the city)
12	Coordinates are centroid of county

98	Latitude and longitude are assigned, but coordinate quality is unknown
99	Latitude and longitude are not assigned, but geocoding was attempted; unable to assign coordinates based on available information
Blank	GIS Coordinate Quality not coded

31405 - Date Case Completed - COC

Field Length: 8

This is a calculated data item which identifies the date that specified items are completed and pass relevant edits, based on the Class of Case (item #30140). This field is used to evaluate compliance by ACoS-approved facilities with Standard 3.3, which specifies that 90% of cases must be completed within six months of the patient's first contact with the facility. It should not be confused with Date Case Completed (item #31410). This field is blank for cases diagnosed prior to January 1, 2010.

Class of Case	Description	Items That Must Be Completed by Date Case Completed - COC
00-22	All analytic cases	Patient identification, demographic, and diagnostic information
10-22	Patient received part or all first course treatment from facility	Staging, hospital-specific treatment
10, 12, 14, 20, 22	Patient received all first course treatment from facility, or unspecified whether all or part	Summary treatment (treatment at any facility)
00	Patient diagnosed at facility, received all treatment elsewhere	Facility referred to OR a treating physician
20-22	Patient diagnosed elsewhere, received part or all of treatment from facility	Facility referred from OR the managing physician

NOTE: This field will be recalculated if the class of case is updated from 00 to any other analytic class of case.

31410 - DATE CASE COMPLETED

Field Length: 11

This item is a calculated field which indicates the date on which the case was initially saved without errors.

31420 - DATE CASE LAST UPDATED

Field Length: 11

This computer generated field records the date the case was most recently updated.

31445 – Import Reporting Facility

Field length: 10

This is a unique code to KCR which represents the facility reporting the case to an out-of-state central registry, such as the Ohio State Cancer Registry or the Veterans Affairs Central Cancer Registry, and then imported into a CPDMS database. This field is automatically coded when an OSDE or VA Central file is imported, and is filled in with the facility's FIN number as contained in the NAACCR import file.

31450 - Area Development District

Field Length: 2

Area Development Districts are multi-county regions of Kentucky, coded as shown below. These are used to calculate regional incidence rates which are more stable than county level rates. This data item is calculated based on the county code; it is not shown on the data entry screen, but is available for data analysis. See also Appendix D for a list of counties and the Area Development Districts in which they are located.

Kentucky's Area Development Districts (ADDs):

(01) Purchase District:

Code	Description
007	Ballard
145	McCracken
039	Carlisle
105	Hickman
075	Fulton
083	Graves
035	Calloway
157	Marshall

(02) Pennyrile District:

Code	Description
139	Livingston
055	Crittenden
143	Lyon
033	Caldwell
107	Hopkins
177	Muhlenberg
221	Trigg
047	Christian
219	Todd

(03) Green River District:

Code	Description
225	Union
233	Webster
101	Henderson
149	McLean
183	Ohio
059	Daviess
091	Hancock

(04) Barren River District:

Code	Description
031	Butler
061	Edmonson
099	Hart
227	Warren
141	Logan
009	Barren
169	Metcalfe
213	Simpson
003	Allen
171	Monroe

(05) Lincoln Trail District:

Code	Description
027	Breckinridge
163	Meade
085	Grayson
093	Hardin
123	Larue
155	Marion
179	Nelson
229	Washington

(06) KIPDA District:

Code	Description
029	Bullitt
111	Jefferson
185	Oldham
223	Trimble
103	Henry
211	Shelby
215	Spencer

(07) Northern Kentucky District:

Code	Description
041	Carroll
187	Owen
081	Grant
191	Pendleton
077	Gallatin
015	Boone
117	Kenton
037	Campbell

(08) Buffalo Trace District:

Code	Description
023	Bracken
201	Robertson
069	Fleming
161	Mason
135	Lewis

(09) Gateway District:

Code	Description
173	Montgomery
165	Menifee
011	Bath
205	Rowan

175	Morgan

(10) FIVCO District:

Code	Description
043	Carter
089	Greenup
019	Boyd
063	Elliott
127	Lawrence

(11) Big Sand District:

Code	Description
153	Magoffin
115	Johnson
071	Floyd
159	Martin
195	Pike

(12) Kentucky River District:

Code	Description
129	Lee
237	Wolfe
189	Owsley
025	Breathitt
193	Perry
119	Knott
133	Letcher
131	Leslie

(13) Cumberland Valley District:

Code	Description
203	Rockcastle
109	Jackson

125	Laurel
235	Whitley
121	Knox
013	Bell
051	Clay
095	Harlan

(14) Lake Cumberland District:

Code	Description
087	Green
217	Taylor
001	Adair
045	Casey
057	Cumberland
053	Clinton
207	Russell
231	Wayne
199	Pulaski
147	McCreary

(15) Bluegrass District:

Code	Description
097	Harrison
209	Scott
073	Franklin
239	Woodford
005	Anderson
167	Mercer
021	Boyle
137	Lincoln
079	Garrard
151	Madison
113	Jessamine
067	Fayette

017	Bourbon
181	Nicholas
049	Clark
065	Estill
197	Powell

31460 - Appalachia Designation

Field Size: 1

There are 52 counties in Kentucky that are designated as part of Appalachia. They are:

Adair
Bath
Bell
Boyd
Breathitt
Carter
Casey
Clark
Clay
Clinton
Cumberland
Elliott
Estill
Fleming
Floyd
Garrard
Green
Greenup
Harlan
Jackson
Johnson
Knott
Knox
Laurel
Lawrence
Lee
Leslie
Letcher
Lewis
Lincoln
Madison
Magoffin
Martin
McCreary
Menifee
Metcalfe
Monroe
Montgomery
Morgan

Nicholas
Owsley
Perry
Pike
Powell
Pulaski
Robertson
Rockcastle
Rowan
Russell
Wayne
Whitley
Wolfe

This is a calculated field which is based on the patient's county of residence at the time of diagnosis. It allows for analysis of study groups based on Appalachian designation. This field is not shown on the data entry screen; however, it is available for data analysis.

Codes

0 = non-KY county
1 = non Appalachian county
2 = Appalachian county

31470 - Beale Code

Field Length: 1

This rural-urban continuum code classifies all U.S. counties by the degree of urbanization and adjacency to a metropolitan area. This code is used in determining eligibility for several Federal programs, and allows researchers to break county-level data into finer residential groups than the standard metro/non-metro.

These codes are based on the June 1993 definition of metropolitan and non-metropolitan counties as determined by the Office of Management and Budget (OMB).

Note: Adjacent counties must not only be physically adjacent to a metropolitan area, but have at least 2 percent of the employed labor force in the non-metro county commuting to central metro counties.

For more information about the rural-urban continuum codes contact:
Calvin Beale (202-694-5416).

*BEALE CODE

Code	Description
0	Central to metro area, 1 million or more
1	Fringe to metro area, 1 million or more
2	Metro county, 250,000 to 1 million
3	Metro county, less than 250,000
4	Urban Pop, 20,000 or more, adjacent to metro
5	Urban Pop, 20,000 or more, not adjacent to metro
6	Urban Pop, 2,500 - 19,999 adjacent to m metro
7	Urban Pop, 2,500 - 19,999, not adjacent to metro
8	Rural, adjacent to metro area
9	Rural, no adjacent to metro area
-1	No Beale Code

This code is calculated from the patient’s county of residence at the time of diagnosis. It is not shown on the data entry screen; however, it is available for data analysis.

31510 - Best Stage Group

Field Length: 2

This is a field calculated by the computer. It does not appear on the Abstract Form. However, it is available for analysis and reporting purposes. It is calculated from the CS derived stage or the pathologic and clinical TNM Stage Groups recorded for this case. For cases diagnosed after 1/1/2004, the Best Stage Group is the CS derived AJCC 6 stage group. For cases diagnosed prior to 1/1/2004, the value in this field is equal to the pTNM Stage Group, unless that value is '88' or '99' or there was pre-operative treatment (p Descriptor is 'Y'). Then it is equal to the value in the cTNM Stage Group.

AJCC 6 Storage Code	Description
00	Stage 0
01	Stage 0a
02	Stage 0is
10	Stage I
11	Stage I NOS
12	Stage IA
13	Stage IA1
14	Stage IA2
15	Stage IB
16	Stage IB1
17	Stage IB2
18	Stage IC
19	Stage IS
20	Stage IEA
21	Stage IEB
22	Stage IE
23	Stage ISA
24	Stage ISB
30	Stage II

31	Stage II NOS
32	Stage IIA
33	Stage IIB
34	Stage IIC
35	Stage IIEA
36	Stage IIEB
37	Stage IIE
38	Stage IISA
39	Stage IISB
40	Stage IIS
41	Stage IIESA
42	Stage IIESB
43	Stage IIES
50	Stage III
51	Stage III NOS
52	Stage IIIA
53	Stage IIIB
54	Stage IIIC
55	Stage IIIEA
56	Stage IIIEB
57	Stage IIIE
58	Stage IIISA
59	Stage IIISB
60	Stage IIIS
61	Stage IIIESA
62	Stage IIIESB
63	Stage IIIES

70	Stage IV
71	Stage IV NOS
72	Stage IVA
73	Stage IVB
74	Stage IVC
88	N/A
90	Stage Occult
99	Stage Unknown

31520 - SEER SITE

Field Length: 5

This field is calculated by the computer. It is based on ICD-O-3 topography and histology codes and is used by SEER to ensure that site/type definitions in the SEER Cancer Statistics Review are consistent over time . These sites can be found at http://seer.cancer.gov/siterecode.

Code	Description
20010	Lip
20020	Tongue
20030	Salivary Gland
20040	Floor of Mouth
20050	Gum and Other Mouth
20060	Nasopharynx
20070	Tonsil
20080	Oropharynx
20090	Hypopharynx
20100	Other Oral Cavity and Pharynx
21010	Esophagus
21020	Stomach
21030	Small Intestine
21041	Cecum
21042	Appendix
21043	Ascending Colon
21044	Hepatic Flexure
21045	Transverse Colon
21046	Splenic Flexure
21047	Descending Colon

21048	Sigmoid Colon
21049	Large Intestine, NOS
21051	Rectosigmoid Junction
21052	Rectum
21060	Anus, Anal Canal and Anorectum
21071	Liver
21072	Intrahepatic Bile Duct
21080	Gallbladder
21090	Other Biliary
21100	Pancreas
21110	Retroperitoneum
21120	Peritoneum, Omentum and Mesentery
21130	Other Digestive Organs
22010	Nose, Naval Cavity and Middle Ear
22020	Larynx
22030	Lung and Bronchus
22050	Pleura
22060	Trachea, Mediastinum and Other Respiratory Organs
23000	Bones and Joints
24000	Soft Tissue including Heart

25010	Melanoma of the Skin
25020	Other Non-Epithelial Skin
26000	Breast
27010	Cervix Uteri
27020	Corpus Uteri
27030	Uterus, NOS
27040	Ovary
27050	Vagina
27060	Vulva
27070	Other Female Genital Organs
28010	Prostate
28020	Testis
28030	Penis
28040	Other Male Genital Organs
29010	Urinary Bladder
29020	Kidney and Renal Pelvis
29030	Ureter
29040	Other Urinary Organs
30000	Eye and Orbit
31010	Brain
31040	Cranial Nerves Other Nervous System
32010	Thyroid
32020	Other Endocrine including Thymus
33011	Hodgkin - Nodal

33012	Hodgkin - Extranodal
33041	NHL Nodal
33042	NHL Extranodal
34000	Myeloma
35011	Acute Lymphocytic Leukemia
35012	Chronic Lymphocytic Leukemia
35013	Other Lymphocytic Leukemia
35021	Acute Myeloid Leukemia
35022	Chronic Myeloid Leukemia
35023	Other Myeloid Leukemia
35031	Acute Monocytic Leukemia
35041	Other Acute Leukemia
35043	Aleukemic, Subleukemic and NOS
36010	Mesothelioma
36020	Kaposi Sarcoma
37000	Miscellaneous Malignant Cancer
99999	Invalid

31530 - Source Status

Field Length: 1

This field identifies the source of all facilities that submitted the case to the central registry. It is automatically calculated at the central registry and does not appear in the patient abstract. It is available for analysis by KCR to identify cases submitted by non-Kentucky facilities.

Source Status is often used to identify cases which cannot be released by KCR to third parties, due to the constraints of data exchange agreements.

Code	Description
1	Kentucky only
2	Out of state only
3	Both Kentucky and out of state

31540 - 31630 - Comorbidities and Complications 1-10

Record the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. These are considered the same as secondary diagnoses.

Instructions for Coding

- Depending on whether the hospital has implemented use of ICD-10-CM, this information may be identified either in ICD-9-CM or ICD-10-CM form. **Do not** record ICD-10-CM codes in the comorbidity fields ; use the secondary diagnoses fields to record ICD-10-CM codes.
- Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters.
- Omit the decimal point between the third and fourth characters.
- If there are fewer than five characters, use zeros after the code to fill the spaces.
- Secondary diagnoses and complications must be reported for patients that have inpatient hospitalizations at your facility.
- Secondary diagnoses and complications should be reported for patients receiving outpatient care or treated in oncology clinics at your facility when available.
- Consult the patient record for the discharge abstract. Secondary diagnoses are found under secondary diagnoses on the discharge abstract. Information from the billing department at your facility may be consulted when a discharge abstract is not available.
- Code the secondary diagnoses in the sequence in which they appear on the discharge abstract or billing list..
- Report the secondary diagnoses for this cancer using the following priority rules:
  - Surgically treated patients:
    a) following the most definitive surgery of the primary site
    b) following other non-primary site surgeries
  - Non-surgically treated patients:
    following the first treatment encounter/episode
  - In cases of non-treatment:
    following the last diagnostic/evaluative encounter
- If the data item *Readmission To The Same Hospital Within 30 Days of Surgical Discharge* is coded 1, 2, or 3, then use available *Comorbidities and Complications* data items to record codes appearing on the "readmission" discharge abstracts that are coded using ICD-9-CM.
- If no ICD-9-CM comorbid conditions or complications were documented, then code 00000 in the first field, and leave the remaining "Comorbidities and Complications" data items blank.
- If fewer than ten secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining "Comorbidities and Complications" data items blank.
- Allowable ICD-9-CM values are:
  00100-13980, 24000-99990,
  E8700-E8799, E9300-E9499

V0720-V0739, V1000-V1590,
V2220-V2310, V2540,
V4400-V4589, V5041-V5049

31640 - ICD Revision Number for Comorbidities and Complications

Field Length: 1

This is a computer generated field based on the Co-morbidities and Complications codes.

Codes	Description
0	No secondary diagnoses reported (Co-morbidities coded 00000)
9	ICD-9 codes used in co-morbidities (all cases with co-morbidities >00000 will be coded 9 automatically)

31650 - Institution Referred From

Field Length: 10

Record the code for the referring hospital where the case was diagnosed or the patient received any therapy for this primary.

For facilities with 6-digit ID numbers that were assigned by the ACoS, CoC before January 1, 2001, use the hospital ID number assigned by the Cancer Department, preceded by 0000. For facilities with 8-digit ID numbers, assigned by CoC after January 1, 2001, use the 8-digit code preceded by two zeros.

EXAMPLE: General Hospital, Anytown, Kentucky, has ID number 510999, would be recorded as 0000510999.

Refer to the list of Kentucky healthcare facility ID numbers in Appendix F. A list of hospital code numbers for other states may be obtained from the CoC web site at: http://www.facs.org/.

When there is no referring hospital, this item should be coded with ten zeros. If the patient was referred by an unknown facility, code the field with 0099999999.

If the patient was hospitalized for the malignancy in more than one hospital, record the code for the most recent hospitalization before this admission.

31660 - Institution Referred To

Field Length: 10

Record the code for the hospital where the patient is referred for definitive treatment following discharge.

For facilities with 6-digit ID numbers that were assigned by the ACoS, CoC before January 1, 2001, use the hospital ID number assigned by the Cancer Department, preceded by 0000. For facilities with 8-digit ID numbers, assigned by CoC after January 1, 2001, use the 8-digit code preceded by two zeros.

EXAMPLE: General Hospital, Anytown, Kentucky, has ID number 510999, would be recorded as 0000510999.

Refer to the list of Kentucky healthcare facility ID numbers in Appendix F. A list of hospital code numbers for other states may be obtained from the CoC web site at: http://www.facs.org/.

If there is no referring hospital, code with 10 zeros. If the patient was referred to an unknown facility, code the field with 0099999999.

If the patient was referred to more than one hospital for definitive treatment, record the first hospital to which the patient was referred.

31670 - Palliative Care (formerly Palliative Procedure)

Field Length: 1

- Record the type of palliative care provided. Palliative care is performed to relieve symptoms and may include surgery, radiation, systemic therapy or other pain management therapy.
- Palliative procedures are not used to diagnose or stage the primary tumor.
- Palliative surgical procedures, radiation therapy, and systemic therapy that are part of first course therapy, which also remove or modify primary or secondary malignant tissue, are **coded here and in the respective therapy fields as well**.

Code	Description
0	No palliative care provided. Diagnosed at autopsy only.
1	Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
2	Radiation therapy to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
3	Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
4	Patient received or was referred for pain management therapy with no other palliative care.
5	Any combination of codes 1, 2, and/or 3 without code 4.
6	Any combination of codes 1, 2, and/or 3 with code 4.
7	Palliative care was performed or referred, but no information on the type of procedure is available in patient record. Palliative care was provided that does not fit the descriptions in codes 1-6.
9	It is unknown if palliative care was performed or referred; not stated in patient record.

31680 - Palliative Procedure At This Facility

Field Length: 1

- Record the type of palliative procedure performed at this facility.
- This item can be entered or updated at any time following the date of diagnosis.
- Palliative procedures are not used to diagnose or stage the primary tumor.
- Palliative surgical procedures, radiation therapy, and systemic therapy that are part of first course therapy are coded in their respective fields.

Code	Description
0	No palliative care provided. Diagnosed at autopsy.
1	Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
2	Radiation therapy to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
3	Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
4	Patient received or was referred for pain management therapy with no other palliative care.
5	Any combination of codes 1, 2, and/or 3 without code 4.
6	Any combination of codes 1, 2, and/or 3 with code 4.
7	Palliative care was performed or referred, but no information on the type of procedure is available in patient record. Palliative care was provided that does not fit the descriptions in codes 1-6.
9	It is unknown if palliative care was performed or referred; not stated in patient record.

31690 - Date of Surgical Discharge

Field Length: 8

Record the date the patient was discharged following primary site surgery. The date corresponds to the event recorded in *Surgical Procedure of Primary Site* and *Date of Most Definitive Surgical Resection*.

- If the patient died following the event recorded in *Surgical Procedure of Primary Site*, but before being discharged from the treating facility, then the *Date of Surgical Discharge* is the same as the date recorded in the data item *Date of Last Contact or Death*.
- If the patient received out-patient surgery, then the date of surgical discharge is the same as the date recorded in the data item *Date of Most Definitive Surgical Resection of the Primary Site*.

Code	Description
MMDDCCYY	The date of surgical discharge is the month, day, and year that the patient was discharged from the hospital following surgical treatment. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
<blank>	When no surgical treatment of the primary site was performed. Diagnosed at autopsy.
99999999	When it is unknown whether surgical treatment was performed, the date is unknown, or the case was identified by death certificate only.

31691 - Date of Surgical Discharge Flag

Field Length: 2

This is a calculated field which explains why there is no appropriate value in the field Date of Surgical Discharge (item #31690). This item is blank for cases diagnosed prior to January 1, 2003.

Codes

Code	Definition
10	No information whatsoever can be inferred (that is, unknown if any surgery was performed)
11	No proper value is applicable in this context (for example, no surgery performed)
12	A proper value is applicable but not known (that is, surgery was performed but the date is unknown)
(blank)	A valid date value is provided

31700 - Readmission to the Same Hospital Within 30 Days of Surgical Discharge

Field Length: 1

Record readmission to the same hospital for the same illness within 30 days of discharge following hospitalization for surgical resection of the primary site.

- Consult patient record or information from the billing department to determine if a readmission to the same hospital occurred within 30 days of the date recorded in the item *Date of Surgical Discharge*.
- Only record a readmission related to the treatment of this cancer.
- Review the treatment plan to determine whether the readmission was planned.
- If there was an unplanned admission following surgical discharge, check for an ICD-9-CM 'E' code, and record it in the co-morbidity fields if space permits.

Code	Description
0	No surgical procedure of the primary site was performed, or the patient was not readmitted to the same hospital within 30 days of discharge.
1	A patient was surgically treated and was readmitted to the same hospital within 30 days of being discharged. This readmission was unplanned.
2	A patient was surgically treated and was then readmitted to the same hospital within 30 days of being discharged. This readmission was planned (chemotherapy port insertion, revision of colostomy, etc.)
3	A patient was surgically treated and, within 30 days of being discharged, the patient had both a planned and an unplanned readmission to the same hospital.
9	It is unknown whether surgery of the primary site was recommended or performed. It is unknown whether the patient was readmitted to the same hospital within 30 days of discharge. Death certificate only.

31710 - CASE TYPE ORIGINAL

Field Length: 1

This field is automatically filled in by the computer. It indicates cases which were originally abstracted as case type 'S' (short forms). The use of short forms was discontinued by KCR in 2000 and all existing short forms were converted to regular abstracts (case type 'A'). These converted cases have certain limitations regarding editing follow-up or adding therapy. Contact KCR technical support staff before attempting to edit cases in which case type original is S.

31720 - CLASS HOSPITAL ID

Field Length: 11

This calculated field displays the facility ID number of the hospital that owns the case. For a multi-facility database, this is the hospital with the highest class of case.

31721 - Patient Accession Number

Field Length: 10

A unique accession number is assigned to each patient for each reporting institution affiliated with the patient. The accession number identifies the patient even if multiple primaries exist. The first four digits of the accession number specify the year in which the patient was first seen at the reporting institution for the diagnosis and/or treatment of cancer. The last six numbers are the numerical order the reporting institution entered their first reportable case of this patient into the registry's database.

The computer calculates these fields by copying in the accession number of the first abstracted case entered by each reporting institution for this patient.

In a single facility database there is only one reporting institution and therefore only one patient accession number for each patient. In a multi-facility database, the patient accession number displayed in the case will be the one associated with the facility in the Class Hospital Id field.

31725 - Archive FIN

Field Length: 10

This field identifies the CoC Facility Identification Number (FIN) of the facility at the time it originally accessioned the case.

When a CoC approved facility merges with another facility or joins a network, its unique FIN may change. Archive FIN preserves the identity of the facility at the time the case was initially accessioned so that records resubmitted subsequent to such a reorganization can be recognized as belonging to the same facility.

Archive FIN is automatically coded by CPDMS.net. This item never changes and must be included as part of the patient record when data are submitted to the NCDB. For facilities that have not merged, Archive FIN and FIN are the same.

31730 - LAST MODIFICATION BY

Field Length: 8

This is a calculated field which records the user name of the last individual to modify case data. It is updated each time the record is edited.

31740 - LAST MODIFICATION TIME

Field Length: 19

This field automatically records the date and time that case data was last modified.

31750 - DATE OF LAST CONTACT OR DEATH

Field Length: 8

Enter the month, day, and year of the last patient contact recorded at the time of abstraction. If the patient has died, the date of death should be recorded here and must be the last date of last contact recorded for this patient.

31760 - SURVIVAL STATUS

Field Length: 1

Enter the one digit code which describes the patient and tumor status at last contact.

Code	Description
1	Alive, no evidence of this tumor present
2	Alive, this tumor present
3	Alive, presence of this tumor unknown
4	Dead, cause unrelated to this tumor - including those dead due to another cancer
5	Dead, due to this tumor
6	Dead from complications related to this tumor
9	Dead, cause unknown

If a patient is recorded as dead (codes 4-9), then none of the seven "Reason No Therapy" fields can be coded 8. Review and update this code, if applicable.

31770 - CANCER STATUS

Field Length: 1

Code	Description
1	No evidence of tumor
2	Tumor present
9	Unknown if cancer present or not

Code this field as of the last time the patient’s vital status and disease status is known. If the patient dies due to an unknown cause, code this field as of the last known status for this disease.

31780 - Length of Survival

Field Size: 4

This is a field calculated by the computer. It does not appear on the Abstract Form. However, it is available for analysis and reporting purposes. It is calculated as the interval of time (in months) from the date of diagnosis to the date of last contact. This calculation is used in survival analyses.

31790 - TYPE OF FIRST RECURRENCE

Field Length: 2

This item identifies the type of first recurrence after a period of documented disease-free intermission or remission.

Instructions for Coding

- Code the type of first recurrence. First recurrence may occur well after completion of the first course of treatment or after subsequent treatment.
- If the patient has never been disease-free (code 70), continue to track for disease-free status. This may occur after subsequent treatment has been completed.
- If the patient is disease-free (code 00), continue to track until a recurrence occurs. First recurrence may occur well after completion of the first course of treatment.
- Once a recurrence has been recorded (code 04-62 or 88), subsequent recurrences are NOT to be recorded.
- Codes 00 through 70 are hierarchical. Record the highest numbered applicable response.
- If the tumor was originally diagnosed as in situ, code recurrence to 06, 16, 17, 26, 27, 36, or 46 only. Do not use those codes for any other tumors. Codes 00, 88, or 99 may apply to any tumor.
- Codes 51-59 (organ or organ system of distant recurrence) apply only if all first occurrences were in a single category. There may be multiple metastases (or "seeding") within the distant location.
- Code lymphomas or leukemias that are in remission 00. If the patient relapses, then code recurrence status as 59. If one of these is controlled by drugs (for example Gleevec for CML), the patient is in remission.
- If there is more than one primary tumor and the physician is unable to decide which has recurred, code the recurrent disease for each tumor. If, at a later date, the recurrent primary is identified, revise the codes as appropriate.

Code	Description
00	Patient became disease-free after treatment and has not had a recurrence
04	In situ recurrence of an invasive tumor
06	In situ recurrence of an in-situ tumor
10	Local recurrence, NOS
13	Local recurrence of an invasive tumor
14	Trocar recurrence of an invasive tumor
15	Combination of 13 and 14
16	Local recurrence of an in situ tumor
17	Both local and trocar recurrence of an in situ tumor

20	Regional, NOS
21	Recurrence of an invasive tumor in adjacent tissue or organ(s) only
22	Recurrence of an invasive tumor in regional lymph nodes only
25	Combination of 21 and 22
26	Regional recurrence of an in situ tumor
27	Combination of 26 with 21, 22 and/or 25
30	Any combination of 10-15 and 20-25
36	Any combination of 16-17 and 26-27
40	Distant recurrence, NOS
46	Distant recurrence of an in situ tumor
51	Distant recurrence of an invasive tumor in the peritoneum only. Peritoneum includes peritoneal surfaces of all structures within the abdominal cavity and/or positive ascitic fluid
52	Distant recurrence of an invasive tumor in the lung only. Lung includes the visceral pleura
53	Distant recurrence of an invasive tumor in the pleura only. Pleura includes the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid
54	Distant recurrence of an invasive tumor in the liver only
55	Distant recurrence of an invasive tumor in bone only. This includes bones other than the primary site
56	Distant recurrence of an invasive tumor in the CNS only. This includes the brain and spinal cord, but **not** the external eye
57	Distant recurrence of an invasive tumor in the skin only. This includes skin other than the primary site
58	Distant recurrence of an invasive tumor in lymph node only. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site
59	Distant systemic recurrence of an invasive tumor only. This includes lymphoma, leukemia, bone marrow metastasis, carcinomatosis, generalized disease
60	Distant recurrence of an invasive tumor in a single distant site (51-58) **and** local, trocar and/or regional recurrence (10-15, 20-25, or 30)
62	Distant recurrence of an invasive tumor in multiple sites (recurrences that can be coded to more than one category 51-59)
70	Since diagnosis, patient has never been disease-free
88	Recurred, site unknown
99	It is unknown whether the disease has recurred or if the patient was ever disease-free

31800 - FIRST DISEASE FREE START DATE

Field Length: 8

Enter the month, day, and year on which the patient was first considered disease-free. Use all information available in the chart when making an evaluation. If it appears that the patient is disease-free, but no exact date is known, make an estimate.

The definition of disease-free status is related to the site of the cancer being studied. With solid tumors, the patient is considered disease-free when there is no reported clinical evidence of any residual tumor (i.e., the pathology report states that the margins are clear) and there is no evidence of cancer in any lymph nodes or metastatic sites. With leukemias, lymphomas, hematopoietic diseases, etc., complete remission is considered a disease-free status. When recording this information for the latter kinds of cases, enter a date only if the record indicates "remission" or "complete remission", leave blank if the record says only "partial remission" or "stable".

31810 - DATE OF FIRST RECURRENCE

Field Length: 8

Enter the month, day, and year of first recurrence since the patient was reported to be disease-free in Item 31800. If a recurrence is evident from the medical chart, but the date of recurrence is not known you must estimate the recurrence date.

If the patient has never been disease-free, or is still in a disease-free state, leave blank.

31811 - Date of First Recurrence Flag

Field Length: 2

This is a calculated field which explains why there is no appropriate value in the field Date of First Recurrence (item #31810).

Codes

Code	Description
10	No information whatsoever can be inferred (that is, unknown if the patient was ever disease free or had a first recurrence)
11	No proper value is applicable in this context (for example, patient became disease free after treatment and never had a recurrence, or patient was never disease free)
12	A proper value is applicable but not known (that is, there was a recurrence but the date is unknown)
(blank)	A valid date value is provided

31820-31860 - SITE OF FIRST RECURRENCE

Field Length: 2 (x5)

Use the General Sites Dictionary in Appendix E and code up to five sites of first recurrence. If not applicable, leave blank.

Precede any single digit codes with a zero.

This field cannot be blank if you put in a recurrence date; code 99 if unknown site.

31870 - First disease free interval

Field Length: 4

This is a field calculated by the computer. It does not appear on the Abstract Form. However, it is available for analysis and reporting purposes. It is calculated as the interval of time (in months) from the date disease free to the date of first recurrence. This field pertains to the first disease free interval only.

31880 - FOLLOWING REGISTRY

Field Length: 10

Record the facility identification number of the registry responsible for following the patient.

This data item is useful when the same patient is recorded in multiple registries.

Instructions for Coding

- For facilities with six-digit FINs that were assigned by the CoC before January 1, 2001, the coded FIN will consist of four leading zeros followed by the full six-digit number.
- For facilities with eight-digit FINs greater than or equal to 10000000 that were assigned by the CoC after January 1, 2001, the coded FIN will consist of two leading zeros followed by the full eight-digit number.

Code	Description
(fill spaces)	Ten-digit facility identification number
0099999999	If the following registry's identification number is unknown

Note: Use Appendix F to find facility ID numbers for Kentucky.

Note: A written agreement may be drawn up between two registries noting which hospital will be responsible for follow-up.

31890 - FOLLOW-UP SOURCE-CENTRAL

Field Length: 2

Record the source from which the latest follow-up information was obtained.

This data item is used by hospital and central registries to identify the most recent source of follow-up information. This item will be used to calculate the Follow-Up Source data item for CoC requirements. It is also used at the Central Registry to reflect the source of information contained in the fields for vital status and date of last contact, particularly when these data come from external file linkages (see codes 01-29).

Source of Information:

Code	Description
(01-29)	**File Linkages (primarily for Central Registry use)**
01	Medicare/Medicaid File
02	Center for Medicare and Medicaid Services (CMS, formerly HCFA)
03	Department of Motor Vehicle Registration
04	National Death Index (NDI)
05	State Death Tape/Death Certificate File
06	County/Municipality Death Tape/Death Certificate File
07	Social Security Administration Death Master File
08	Hospital Discharge Data
09	Health Maintenance Organization (HMO) file
10	Social Security Epidemiological Vital Status Data
11	Voter Registration File
12	Research/Study Related Linkage
29	Linkages, NOS
(30-39)	**Hospitals and Treatment Facilities**
30	Hospital inpatient/outpatient
31	Casefinding
32	Hospital cancer registry
33	Radiation treatment center

34	Oncology clinic
35	Ambulatory surgical center
39	Clinic/facility, NOS
(40-49)	**Physicians**
40	Attending physician
41	Medical oncologist
42	Radiation oncologist
43	Surgeon
48	Other specialist
49	Physician, NOS
(50-59)	**Patient**
50	Patient contact
51	Relative contact
59	Patient, NOS
(60-98)	**Other**
60	Central or Regional cancer registry
61	Internet sources
62	Hospice
63	Nursing homes
64	Obituary
65	Other research/study related sources
98	Other, NOS
99	Unknown source

31900 - FOLLOW-UP SOURCE

Field Length: 1

Records the source from which the latest follow-up information was obtained.

This data item is used by hospital and central registries to identify the most recent source of follow-up information.

Instructions for Coding

Code	List	Description
0	Reported hospitalization	Hospitalization at another institution/hospital or first admission to the reporting facility
1	Readmission	Hospitalization or outpatient visit at the reporting facility
2	Physician	Information from a physician
3	Patient	Direct contact with the patient
4	Dept of Motor Vehicles	The Department of Motor Vehicles confirmed the patient has a current license
5	Medicare/Medicaid file	The Medicare or Medicaid office confirmed the patient is alive
7	Death certificate	Information from the death certificate only
8	Other	Friends, relatives, employers, other registries, or any sources not covered by other codes
9	Unknown; not stated in patient record	The follow-up source is unknown or not stated in patient record

Starting with 2006 cases, this field is calculated from Follow-Up Source - Central.

31910 - NEXT FOLLOW-UP METHOD

Field Length: 2

Record the code that describes the primary source of follow-up information to be contacted on the next follow-up attempt.

Code	Description
00	Lost to follow up
01	Primary following physician (coded in item 31100)
02	Follow-up Physician 2 (coded in item 31110)
03	Follow-up Physician 3 (coded in item 31120)
04	Patient by letter
05	Patient by phone call
06	Other contact person (coded in items 31930-32020)
07	Public records, agencies, newspapers, etc
08	Hospital chart/records
09	No follow up required
10	Follow-up Physician 4 (coded in item 31121)
11	Follow-up Physician 5 (coded in item 31122)

There is an edit check between this field and the patient level field "Contact Patient" (item 10301). When Contact Patient is coded '0', this field cannot be coded '04' ("Patient by letter") or '05' ("Patient by phone call").

31920 - Alternate follow-up Method

Field Length: 2

Record the code which describes the alternate source to be contacted for follow-up information.

Code	Description
00	Lost to follow up
01	Primary following physician (coded in item 31100)
02	Follow-up Physician 2 (coded in item 31110)
03	Follow-up Physician 3 (coded in item 31120)
04	Patient by letter
05	Patient by phone call
06	Other contact person (coded in items 31930-32020)
07	Public records, agencies, newspapers, etc
08	Hospital chart/records
09	No follow up required
10	Follow-up Physician 4 (coded in item 31121)
11	Follow-up Physician 5 (coded in item 31122)

There is an edit check between this field and the patient level field "Contact Patient" (item 10301). When Contact Patient is coded '0', this field cannot be coded '04' ("Patient by letter") or '05' ("Patient by phone call").

31100 - PRIMARY FOLLOWING PHYSICIAN

Field Length: 7

This field is provided for entry of a code number assigned to the physician following this patient for treatment at this institution. Use the physician's Kentucky License Number and develop your own codes for identifying out-of-state physicians who may be following your patients.

The web site for the Kentucky Board of Medical Licensure is located at: http://kbml.ky.gov/. The link for the online directory is found under Online Searches, called Physician Profile/Verification of Physician License.

A lookup for NPI numbers is available at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

This field will be used to generate mailing labels to physicians to use with your follow up letters.

Hospitals may code '9999999' for "Unknown", but this field may not be left blank.

31110 - Follow-Up Physician 2

Field Length: 7

This field is provided for entry of a code number assigned to an additional follow up physician for this patient. Use the Kentucky License Number, or your own code numbers developed for identifying out-of-state physicians. The web site for the Kentucky Board of Medical Licensure is located at: http://kbml.ky.gov/. The link for the online directory is found under Online Searches, called Physician Profile/Verification of Physician License.

A lookup for NPI numbers is available at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

This field may also be used to generate mailing labels for follow up letters to these physicians.

Hospitals may use a special code for "Unknown" and/or leave this field blank if there is no alternate follow up physician.

31120 - Follow-up Physician 3

Field Length: 7

This field is provided for entry of a code number assigned to any physician involved with this patient and who may potentially be a source of follow up information. Use the Kentucky License Number, or your own code developed for identifying out-of-state physicians. The web site for the Kentucky Board of Medical Licensure is located at: http://kbml.ky.gov/. The link for the online directory is found under Online Searches, called Physician Profile/Verification of Physician License.

A lookup for NPI numbers is available at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

This field may be used to generate mailing labels for follow up letters to these physicians.

Hospitals may use a special code for "Unknown" and/or leave this field blank if there was no other physician.

31121 - Follow-up Physician 4

Field Length: 7

This field is provided for entry of a code number assigned to an additional follow up physician for this patient. Use the Kentucky License Number, or your own code numbers developed for identifying out-of-state physicians. The web site for the Kentucky Board of Medical Licensure is located at: http://kbml.ky.gov/. The link for the online directory is found under Online Searches, called Physician Profile/Verification of Physician License.

A lookup for NPI numbers is available at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

This field may also be used to generate mailing labels for follow up letters to these physicians.

Hospitals may use a special code for "Unknown" and/or leave this field blank if there is no alternate follow up physician.

31122 - Follow-up Physician 5

Field Length: 7

This field is provided for entry of a code number assigned to an additional follow up physician for this patient. Use the Kentucky License Number, or your own code numbers developed for identifying out-of-state physicians. The web site for the Kentucky Board of Medical Licensure is located at: http://kbml.ky.gov/. The link for the online directory is found under Online Searches, called Physician Profile/Verification of Physician License.

A lookup for NPI numbers is available at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

This field may also be used to generate mailing labels for follow up letters to these physicians.

Hospitals may use a special code for "Unknown" and/or leave this field blank if there is no alternate follow up physician.

31930 - Other contact person - Last name

Field Length: 20

Enter the last name of the patient's closest living relative, or friend, who may be contacted for follow-up information.

Otherwise, leave blank; this field is merely an aid for follow-up.

31940 - Other Contact Person - First name

Field Length: 15

Enter the first name of the patient's closest living relative or friend, who may be contacted for follow up information.

This field is an aid for follow-up, and may be left blank.

31950-31960 - Other Contact Person - Address Line 1 and Line 2

Field Length: 20 (x2)

Enter the address of the patient's closest living relative, or friend.

This field is an aid for follow-up, and may be left blank.

31970 - Other Contact Person - City

Field Length: 20

Enter the city of the address of the patient's closest living relative, or friend.

This field is an aid for follow-up, and may be left blank.

31980 - Other Contact Person - State

Field Length: 2

Enter the state abbreviation for the address of the patient's closest living relative, or friend. This field is an aid for follow-up, and may be left blank.

31990-32000 - Other Contact Person - ZIP Code

Field Length: 9

Enter the ZIP code of the address of the patient's closest living relative, or friend.

This field is an aid for follow-up, and may be left blank.

32010 - Other Contact Person - Telephone No.

Field Length: 10

Enter the telephone number of the patient's closest living relative, or friend.

This field is an aid for follow-up, and may be left blank.

32020 - Other Contact Person - Relationship

Field Length: 15

Enter the relationship of the other contact person to the patient. For example,

Spouse
Father
Mother
Sister
Brother
Son
Daughter
Grandparent
Neighbor, etc.

32030 - Follow-Up Text

Field Length: 30

This field may be used to type in any pertinent information about follow-up. It is an optional field and may be left blank.

32040 - LAST FOLLOW-UP HOSPITAL ID

Field Length: 11

This field does not appear on the abstract but is available for data analysis. It is auto filled with the facility ID number of the hospital which most recently updated the patient’s record. This field is mainly utilized in multi-facility registries and at the central registry.

32050 - LAST MODIFICATION BY

Field Length: 8

This is a calculated field which records the user name of the last individual to modify follow-up data. It is updated each time the record is edited.

32060 - LAST MODIFICATION TIME

Field Length: 19

This field automatically records the date and time that follow-up data was last modified.

32070-32260 - User Defined Fields - Case Level

Field Length: 15 (x20)

This element provides up to 20 fifteen-digit fields for coding additional diagnostic procedures or other relevant information at the case level. These will be user defined fields based on the individual institution's need or desire to track patterns of diagnostic and other procedures with particular types of cancer patients.

For example: The following codes for colon cancers could be established for the first three fields:

A. Patient Height
B. Patient Weight
C. Diagnosed Via Screening Colonoscopy? (Y/N)

32270-32480 - Override Flags

Field Length: 1 (x22)

a. SummStg/Nodes+
b. SummStg/TNM-N
c. SummStg/TNM-M
d. SummStg/Mets1
e. Accn#/Class/Seq
f. HospSeq/DxConfirm
g. COC-Site/Type
h. HospSeq/Site
i. Site/TNM Stg Grp
j. Age/Site (IF 15)
k. Seq/DiagConfirm (IF 23)
l. Site/Histo/Lat/Seq (IR 09)
m. Surg/DxConfirm (IF 46)
n. Site/Type (IF 25)
o. Histo/Behave (MORPH)
p. Reporting Source/Seq (IF 04)
q. Seq/Ill-defined site (IF 22)
r. Leukemias/Lymphomas (IF 48)
s. Site/Behave (IF 39)
t. Site/EOD/DxDate (IF 40)
u. Site/Lat/EOD (IF 41)
v. Site/Lat/Morph (IF 42)

Override flags are available to indicate that a record with apparently inconsistent or unlikely data has been reviewed and is in fact correct as coded. Enter a '1' in the field that describes the edit check that is to be overridden.

Override flags a-d (fields 32270-32300) are not used by KCR. Override flags e-v are described in greater detail on the following pages.

32310 - Override ACSN/Class/Seq

The edit, *Accession Number, Class of Case, Seq Number* (CoC), checks the following:

- If the case is the only case or the first of multiple cases diagnosed at the facility (ACoS Sequence Number = 00, 01, 60 or 61, and Class of Case = 0, 1, or 6), then the first 4 characters of the *Accession Number* must equal the year of the *Date of First Contact*.
- If the case is first diagnosed at autopsy (Class of Case = 5), and the case is the only case or the first of multiple cases for a patient (ACoS Sequence Number = 00, 01, 60, or 61), then the first 4 characters of the *Accession Number* must equal the year of the *Date of Last Contact or Death* AND must equal the year of the *Date of First Contact*.
- If the case is first diagnosed at autopsy (Class of Case = 5), and the case is the second or more case for a patient (ACoS Sequence Number greater than 01 or greater than 61), then the year of the *Date of First Contact* must equal the year of *Date of Last Contact or Death*.

There are some exceptions to the above rules. *Override Acsn/Class/Seq* may be used to override the edit when the circumstances fit the following situation or one similar to it:

- The case may be the only or the first of multiple malignant cases for a patient (ACoS Sequence Number = 00 or 01), but there is an earlier benign case (with an earlier year of the *Date of First Contact*) for which the *Accession Number* applies.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the edit *Accession Number, Class of Case, Sequence Number* (CoC).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

32320 - Override Hospseq/Dxconf

The edit, *Diagnostic Confirm, Seq Num–Hosp* (CoC), does the following:

· If any case is one of multiple primaries and is not microscopically confirmed or positive lab test/marker study, i.e., Diagnostic Confirmation > 5 and ACoS Sequence Number > 00 (more than one primary), review is required.
· If *Primary Site* specifies an ill-defined or unknown primary (C76.0–C76.8, C80.9), no further checking is done. If ACoS Sequence Number is in the range of 60-88, this edit is skipped.

It is important to verify that the non-microscopically-confirmed case is indeed a separate primary from any others that may have been reported. This edit forces review of multiple primary cancers when one of the primaries is coded to a site other than ill-defined or unknown and is not microscopically confirmed or confirmed by a positive lab test/marker study.

· If this edit is failed and the suspect case is confirmed accurate as coded, and the number of primaries is correct, set the *Override HospSeq/DxConf* to 1. Do not set the override flag on the patient's other primary cancers.
· However, if it turns out that the non-microscopically-confirmed cancer is considered a manifestation of one of the patient's other cancers, delete the non-microscopically-confirmed case. Check the sequence numbers of remaining cases, correcting them if necessary. Also check for other data items on the remaining cases that may need to be changed as a result of the corrections, such as stage and treatment.

Instructions for Coding
· Leave blank if the EDITS program does not generate an error message for the edit *Diagnostic Confirm, Seq Num–Hosp* (CoC).
· Leave blank and correct any errors for the case if an item is discovered to be incorrect.
· Code 1 if a review of all items in the error or warning message confirms that all are correct

32330 - Override CoC - Site/Type

There are multiple versions of edits of the type, *Primary Site, Morphology-Type*, which check for "usual" combinations of site and ICD-O-2 or ICD-O-3 histology. The SEER version of the edit is more restrictive than the CoC edit, and thus uses a different override flag. The CoC version of the edit will accept Override CoC-Site/Type or Override Site/Type as equivalent.

· The Site/Histology Validation List (available on the SEER Web site) contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never are not be included. These edits require review of all combinations *not* listed.
· Since basal and squamous cell carcinomas of non-genital skin sites are not reportable to SEER, these site/histology combinations do not appear on the SEER validation list. For the CoC version of the edit, if *Primary Site* is in the range C44.0-C44.9 (skin), and the ICD-O-3 histology is in the range 8000-8005 (neoplasms, malignant, NOS), 8010-8046 (epithelial carcinomas), 8050-8084 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), no further editing is done. No override is necessary for these cases in the CoC version of the edit.

Review of these cases requires investigating whether the combination is biologically implausible or there are cancer registry coding conventions that would dictate different codes for the diagnosis. Review of these rare combinations often results in changes to the primary site and/or morphology, rather than a decision that the combination is correct.

Instructions for Coding
· Leave blank if the EDITS program does not generate an error message for edits of the type *Primary Site, Morphology-Type Check.*
· Leave blank and correct any errors for the case if an item is discovered to be incorrect.
· Code 1 if a review of all items in the error or warning message confirms they are correct and coded in conformance with coding rules.

32340 - Override Hospseq/Site

Edits of the type, *Seq Num--Hosp, Primary Site, Morph,* differ in use of ICD-O-2 or ICD-O-3 morphology. They force review of multiple primary cancers when one of the primaries is coded to a site-morphology combination that could indicate a metastatic site rather than a primary site. If *ACoS Sequence Number* indicates the person has had more than one primary, then any case with one of the following site-histology combinations requires review:

· C76.0–C76.8 (Ill-defined sites) or C80.9 (unknown primary) and ICD-O-2 or ICD-O-3 histology < 9590. (Look for evidence that the unknown or ill-defined primary is a secondary site from one of the patient's other cancers. For example, a clinical discharge diagnosis of "abdominal carcinomatosis" may be attributable to the patient's primary ovarian cystadenocarcinoma already in the registry, and should not be entered as a second primary.)
· C77.0-C77.9 (lymph nodes) and ICD-O-2 histology not in range 9590-9717 or ICD-O-3 histology not in the range 9590-9729; or C42.0-C42.4 and ICD-O-2 histology not in range 9590-9941 or ICD-O-3 histology not in the range 9590-9989. (That combination is most likely a metastatic lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers.)
· Any site and ICD-O-2 histology in the range 9720-9723, 9740-9741 or ICD-O-3 histology in the range 9740-9758. (Verify that these diagnoses are coded correctly and are indeed separate primaries from the others.)

If it turns out that the suspect tumor is a manifestation of one of the patient's other cancers, delete the metastatic or secondary case, re-sequence remaining cases, and correct the coding on the original case as necessary.

Instructions for Coding
· Leave blank if the EDITS program does not generate an error message for an edit of the type Seq Num--Hosp, Primary Site, Morph
· Leave blank and correct any errors for the case if an item is discovered to be incorrect.
· Code 1 if review of all items in the error or warning message confirms that all are correct.

32350 - Override Site/TNM-Stage Group

The edit, *Primary Site, AJCC Stage Group - Edition 6 (COC),* checks that the pathologic and clinical AJCC stage group codes are valid for the site and histology group according to the *AJCC Cancer Staging Manual, Sixth Edition,* using the codes described for the items *Clinical Stage Group* and *Pathologic Stage Group*. Combinations of site and histology not represented in any AJCC schema must be coded 88. Unknown codes must be coded 99. Blanks are not permitted.

Since pediatric cancers whose sites and histologies have an AJCC scheme may be coded according to a pediatric scheme instead, *Override Site/TNM-Stage Group* is used to indicate pediatric cases not coded according to the AJCC manual. Pediatric stage groups should *not* be recorded in the *Clinical Stage Group* or *Pathologic Stage Group* items. When neither clinical nor pathologic AJCC staging is used for pediatric cases, code all AJCC items 88. When any components of either is used to stage a pediatric case, follow the instructions for coding AJCC items and leave *Override Site/TNM-Stage Group* blank.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the edit, *Primary Site, AJCC Stage Group - Edition 6 (COC).*
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case is confirmed to be a pediatric case that was coded using a pediatric coding system.

32360 - Override Age/Site/Morph (IF 15)

Edits of the type, *Age, Primary Site, Morphology* differ in using ICD-O-2 or ICD-O-3 morphologies, and require review if a site-ICD-O-3 morphology combination occurs in an age group for which it is extremely rare:

Age	Morphology	Site
< age 15	any histology with behavior = 2	C53._
< age 15	9100	C58._
< age 20	any histology	C15._ , C17._ , C19._-C21._ , C23._ -C25._, C38.4, C50._, C54._ -C55._
< age 20	any histology other than 8240-8245	C18._ , C33._ -C34._
< age 20	any histology with behavior = 3	C53._
< age 30	9732, 9823, 9863, 9875-9876, 9945, 9946	any site
< age 30	any histology	C60.9
< age 45	8140	C61.9
> age 5	9510-9514	C69._
> age 14	8960	any site
> age 45	9100	C58.9

If the edit generates an error or warning message, check that the primary site and histologic type are coded correctly and that the age, date of birth, and date of diagnosis are correct.

Instructions for Coding

· Leave blank if the EDITS program does not generate an error message (and if the case was not diagnosed in utero) for the edit *Age, Primary Site, Morphology* (CoC) and/or the edit *Age, Primary Site, Morphology ICD-O-3* (CoC).

· Leave blank and correct any errors for the case if an item is discovered to be incorrect.

· Code 1, 2, or 3 as indicated if review of all items in the error or warning message confirms that all are correct.

Codes

1. Reviewed: An unusual occurrence of a particular age/site/histology combination for a given age group has been reviewed.
2. Reviewed: Case was diagnosed in utero
3. Reviewed: Conditions 1 and 2 above both apply

32370 - Override Sequence Number/Diagnostic Confirmation (IF23)

This edit forces review of multiple primary cancers when one of the primaries is coded to a site other than ill-defined or unknown and is not microscopically confirmed or confirmed by a positive lab test/marker study. It is important to verify that the non-microscopically-confirmed case is indeed a separate primary from any others that may have been reported. If the suspect case is accurate as coded, and the number of primaries is correct, set the Override SeqNo/DxConf flag to 1 so that the case will not appear in future edits as an error. It is not necessary to set the override flag on the patient's other primary cancers.

If it turns out that the non-microscopically-confirmed cancer is considered a manifestation of one of the patient's other cancers, delete the non-microscopically-confirmed case. Check the sequence numbers of remaining cases, correcting them if necessary.

Instructions for Coding

· Leave blank if the EDITS program does not generate an error message for the edit Sequence Number/Diagnostic Confirmation.
· Leave blank and correct any errors for the case if an item is discovered to be incorrect.
· Code 1 if review of all items in the error or warning message confirms that all are correct.

32380 - Override Site/Histology/Laterality/Sequence (IR 09)

Given two records for the same person coded with the same three-digit histology code and - in cases where the sites are paired organs, the same known laterality (see Table 2) - there must be no ambiguity of primary site between specified and NOS. That is, if the site code in one of the records appears in the left column of Table 1 below, then the site in the other records must not occur in the same line on the right side of the table. This edit is performed only for invasive diagnoses (Behavior = 3).

Table 1

NOS	Specified
CAA8	CAAx
CBB9	CBBx
C260	C150-C259, C480-C488
C268	C150-C259, C480-C488
C269	C150-C259, C480-C488
C390	C300-C349, C384
C398	C300-C349, C380-C388
C399	C300-C349, C384
C579	C510-C578, C589
C639	C600-C638
C689	C649-C688
C758	C379, C739-C749
C759	C379, C739-C749

(Where AA represents any two-digit number except 16, 53, 71; BB represents any two-digit number and x represents any one-digit number.)

Table 2

Paired Organs

Code	Description
C491	Connective, subcutaneous, and other soft tissues of upper limb and shoulder

C492	Connective, subcutaneous, and other soft tissues of lower limb and hip

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for this edit.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

32390 - Override Surg/Dxconf (IF 46)

Edits of the type, *RX Summ-Surg Prim Site*, *Diag Conf*, check that cases with a primary site surgical procedure coded 20-90 are histologically confirmed.

If the patient had a surgical procedure, most likely there was a microscopic examination of the cancer.

- Verify the surgery and diagnostic confirmation codes, and correct any errors.
- Sometimes there are valid reasons why no microscopic confirmation is achieved with the surgery, for example, the tissue removed may be inadequate for evaluation.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for edits of the type, *RX Summ-Surg Prim Site*, *Diag Conf*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

32400 - Override Site/Type (IF 25)

There are multiple versions of edits of the type, *Primary Site*, *Morphology-Type*, which check for "usual" combinations of site and ICD-O-2 or ICD-O-3 histology. The SEER version of the edit is more restrictive than the CoC edit, and thus uses a different override flag. The CoC version of the edit will accept Override CoC-Site/Type or Override Site/Type as equivalent.

- The Site/Histology Validation List (available on the SEER website) contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never are not be included. These edits require review of all combinations *not* listed.
- Since basal and squamous cell carcinomas of non-genital skin sites are not reportable to SEER, these site/histology combinations do not appear on the SEER validation list. For the CoC version of the edit, if *Primary Site* is in the range C440-C449 (skin), and the ICD-O-3 histology is in the range 8000-8005 (neoplasms, malignant, NOS), 8010-8046 (epithelial carcinomas), 8050-8084 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), no further editing is done. No override is necessary for these cases in the CoC version of the edit.

Review of these cases requires investigating whether the combination is biologically implausible or there are cancer registry coding conventions that would dictate different codes for the diagnosis. Review of these rare combinations often results in changes to the primary site and/or morphology, rather than a decision that the combination is correct.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the edit Primary Site, Morphology-Type Check (SEER IF25) and/or the edit Primary Site, Morphology-Type ICDO3 (SEER IF25).
    - Leave blank and correct any errors for the case if an item is discovered to be incorrect.
    - Code 1 if review of all items in the error or warning message confirms that all are correct.

32410 - Override Histology/Behavior (IF 31/SEER MORPH)

I. Edits of the type, *Diagnostic Confirmation, Behavior Code*, differ in the use of ICD-O-2 or ICD-O-3 and check that, for in situ cases (Behavior = 2), *Diagnostic Confirmation* specifies microscopic confirmation (1, 2 or 4). The distinction between in situ and invasive is very important to a registry, since prognosis is so different. Since the determination that a neoplasm has not invaded surrounding tissue, i.e. is in situ, is made microscopically, cases coded in situ in behavior should have a microscopic confirmation code. **Note:** Very rarely, a physician will designate a case noninvasive or in situ without microscopic evidence.

If an edit of the type, *Diagnostic Confirmation, Behavior Code*, gives an error message or warning, check that *Behavior Code* and *Diagnostic Confirmation* have been coded correctly. Check carefully for any cytologic or histologic evidence that may have been missed in coding.

II. Edits of the type, *Morphology-Type/Behavior*, perform the following overrideable check:

- Codes listed in ICD-O-2 or ICD-O-3 with behavior codes of only 0 or 1 are considered valid, since use of the behavior matrix of ICD-O-2 and ICD-O-3 allows for the elevation of the behavior of such histologies when the tumor is in situ or malignant. This edit forces review of these rare cases to verify that they are indeed in situ or malignant.

If a *Morphology-Type/Behavior* edit produces an error or warning message and the case is one in which the 4-digit morphology code is one that appears in ICD-O-2 or ICD-O-3 only with behavior codes of 0 or 1, verify the coding of morphology and that the behavior should be coded malignant or in situ. The registrar may need to consult a pathologist or medical advisor in problem cases.

Exceptions to the above: If year of *Date of Diagnosis* > 2000, then a behavior code of 1 is valid for the following ICDO-2 histologies and no override flag is needed: 8931, 9393, 9538, 9950, 9960-9962, 9980-9984, 9989. Similarly, the following ICD-O-3 histologies are valid with a behavior code of 1: 8442, 8451, 8462, 8472, and 8473.

Note: The Morphology-Type/Behavior edits are complex and perform several additional types of checks. No other aspects of their checks are subject to override.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the edits of the types Diagnostic Confirmation, Behavior Code or Morphology-Type/Behavior
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1, 2 or 3 as indicated if review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed
1	Reviewed; allow flag for edits of the type Morphology- Type/Behavior (SEER MORPH)
2	Reviewed; allow glad for edits of the type Diagnostic Confirmation, Behavior Code (IF 31)
3	Reviewed; conditions 1 and 2 above both apply

32420 - Override Type of Reporting Source/Sequence Number (IF 04)

If the Type of Reporting Source specifies a death certificate only case (7) and Histology is not a lymphoma, leukemia, immunoproliferative or myeloproliferative disease (<9590), then ACoS Sequence Number must specify one primary only (00).

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for this edit.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

32430 - Override Sequence Number/Ill-defined Site (IF 22)

This edit forces review of multiple primary cancers when one of the primaries is coded to a site-morphology combination that could indicate a metastatic site rather than a primary site.

GENERAL
It is important to verify that the suspect case is indeed a separate primary from any others that may have been reported for the patient. Correction of errors may require inspection of the abstracted text, either online or as recorded on a paper abstract. Review of the original medical record may be necessary. If the suspect case is accurate as coded, and the number of primaries is correct, set the Over-ride Ill-define site flag to 1 so that the case will not be considered in error when the edit is run again. It is not necessary to set the over-ride flag on the patient's other primary cancers.

If it turns out that the suspect cancer is considered a manifestation of one of the patient's other cancers, delete the former case, resequence remaining cases, and correct the coding on the latter case as necessary.

SPECIFIC GUIDELINES
1. Ill-defined sites (C76.0 - C76.8) or unknown primary (C80.9) and histology code less than 9590: Look for evidence that the unknown or ill-defined primary is a secondary site (extension or metastasis) from one of the patient's other cancers. For example, a clinical discharge diagnosis of "r;abdominal carcinomatosis" may be attributable to the patient's primary ovarian cystadenocarcinoma known to the registry, and should not be entered as a second primary.

2. Lymph nodes (C77.0 - C77.9) and histology code not in the range 9590-9714: Primary malignancies of lymph nodes are almost exclusively the lymphomas coded in the range 9590-9714. A carcinoma, sarcoma, leukemia, or other diagnosis outside that range in a lymph node is most likely a metastatic (secondary) lesion. Check whether the lymph node lesion could be a manifestation of one of the patient's other cancers. If the lesion in the lymph node is considered a separate primary, try to ascertain a more appropriate primary site than lymph nodes.

3. Hematopoietic and reticuloendothelial systems (C42.0 - C42.4) and histology not in the range 9590-9941: Primary cancers of the blood, bone marrow, spleen, etc. are almost exclusively lymphomas, leukemias, and related conditions coded in the range 9590-9941. A carcinoma, sarcoma, or other diagnosis outside that range in one of these sites is most likely a metastatic (secondary) lesion. Check whether the lesions could be a manifestation of one of the patient's other cancers. If the lesion is considered a separate primary, try to ascertain a more appropriate primary site other than those in the C42 group.

4. Other lymphoreticular neoplasms and mast cell tumors of any site (histologies 9720-9723 and 9740-9741): Verify that these diagnoses are coded correctly and are indeed separate primaries from the other reported ones.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for this edit.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

32440 - Override Leukemia, Lymphoma (IF 48)

Edits of the type, *Diagnostic Confirmation, Histol Type,* differ in use of ICD-O-2 or ICD-O-3 and check the following:

- Since lymphoma and leukemia are almost exclusively microscopic diagnoses, this edit forces review of any cases of lymphoma that have diagnostic confirmation of direct visualization or clinical, and any leukemia with a diagnostic confirmation of direct visualization.
- If histology is 9590-9717 for ICD-O-2 or 9590-9729 for ICD-O-3 (lymphoma), then *Diagnostic Confirmation* cannot be 6 (direct visualization) or 8 (clinical).
- If histology is 9720-9941 for ICD-O-2 or 9731-9948 for ICD-O-3 (leukemia and other), then *Diagnostic Confirmation* cannot be 6 (direct visualization).

In an edit of the type, *Diagnostic Confirmation, Histol Type,* produces an error or warning message, check that the *Histology* and *Diagnostic Confirmation* are correctly coded. Remember that positive hematologic findings and bone marrow specimens are included as histologic confirmation (code 1 in *Diagnostic Confirmation*) for leukemia.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the edits of the type *Diagnostic Confirmation, Histol Type.*
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

32450 - Override Site/Behavior (IF 39)

Edits of the type, *Primary Site, Behavior Code*, require review of the following primary sites with a behavior of in situ (ICD-O-2 or ICD-O-3 behavior = 2):

Code	Description
C26.9	Gastrointestinal tract, NOS
C39.9	Ill-defined sites within respiratory system
C55.9	Uterus, NOS
C57.9	Female genital tract, NOS
C63.9	Male genital organs, NOS
C68.9	Urinary system, NOS
C72.9	Nervous system, NOS
C75.9	Endocrine gland, NOS
C76.0-C76.8	Ill-defined sites
C80.9	Unknown primary site

Since the designation of in situ is very specific and almost always requires microscopic confirmation, ordinarily specific information should also be available regarding the primary site. Conversely, if inadequate information is available to determine a specific primary site, it is unlikely that information about a cancer being in situ is reliable.

- If a specific in situ diagnosis is provided, try to obtain a more specific primary site. A primary site within an organ system can sometimes be identified based on the diagnostic procedure or treatment given or on the histologic type. If a more specific site cannot be determined, it is usually preferable to code a behavior code of 3. In the exceedingly rare situation in which it is certain that the behavior is in situ and no more specific-site code is applicable, set *Override Site/Behavior* to 1.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the edit *Primary Site, Behavior Code* (CoC) and/or the edit *Primary Site, Behavior Code* ICD-O-3 (CoC)**.**
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.

- Code 1 if review of all items in the error or warning message confirms that all are correct.

32460 - Override Site/EOD/Diagnosis Date (IF 40)

The following cancers require review if reported with localized extent of disease:

Code	Description
C069	Mouth, NOS
C189	Colon, NOS not histology 8220 (adenocarcinoma in adenomatous polyposis coli)
C260-C269	Other and ill-defined digestive organs
C390-C399	Other and ill-defined respiratory or intrathoracic sites
C409, C419	Bone, NOS
C479	Peripheral nerves, NOS
C499	Connective tissue, NOS
C559	Uterus, NOS
C579	Female genital system, NOS
C639	Male genital organs, NOS
C760-C768	Other and ill-defined sites
C809	Unknown primary site

The definition of localized disease for each of the extent of disease coding systems is: 10-30.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for this edit**.**
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

32470 - Override Site/Laterality/EOD (IF 41)

The IF41 edit for paired organs does not allow EOD to be specified as in situ, localized, or regional by direct extension if laterality is coded as "bilateral, side unknown" or "laterality unknown." Review the source information and use code 3 - One side only, right or left origin unknown - if it applies. Use this override to indicate that the conflict has been reviewed.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for this edit**.**
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

32480 - Override Site/Lat/Morph (IF 42)

Edits of the type, *Laterality, Primary Site, Morph*, differ in whether they produce a warning or an error message and in use of ICD-O-2 or ICD-O-3 morphology. This edit checks the following:

- If the *Primary Site* is a paired organ and *Behavior Code* is in situ (2), then *Laterality* must be 1, 2, or 3.
- If diagnosis year is less than 1988 and *Histology* is greater than or equal to 9590, then no further editing is performed. If diagnosis year is greater than 1987 and *Histology* equals 9140, 9700, 9701, 9590-9980, then no further editing is performed.

The intent of this edit is to force a review of in situ cases for which *Laterality* is coded 4 (bilateral) or 9 (unknown laterality) as to origin.

- In rare instances when the tumor is truly midline (9) or the rare combination is otherwise confirmed correct, enter code 1 for *Override Site/Lat/Morph.*

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the edit *Laterality, Primary Site, Morphology* (SEER IF42) and/or the edit *Laterality, Primary Site, Morph*
  ICD-O-3 (SEER IF42).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

32820 - 33010 - CS Override 1-20

These overrides will be used with collaborative stage edits. They are currently undefined.

33020 - 33110 - Secondary Diagnoses 1-10

Field Length: 5 (x10)

Record the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-10-CM codes. The secondary diagnoses are also called comorbidities and complications.

Instructions for Coding

- Use this item to record ICD-10-CMcodes. Use *Comorbidities and Complications* to record ICD-9-CMcodes. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, only the actual ICD-10-CMcode is to be entered for *Secondary Diagnosis* fields, leaving blanks beyond those characters.
- Omit the decimal points when coding.
- Secondary diagnoses are found on the discharge abstract. Information from the billing department at your facility may be consulted when a discharge abstract is not available.
- Code the secondary diagnoses in the sequence in which they appear on the discharge abstract or are recorded by the billing department at your facility.
- Report the secondary diagnoses for this cancer using the following priority rules:
  - Surgically treated patients:
    a) following the most definitive surgery of the primary site
    b) following other non-primary site surgeries
  - Non-surgically treated patients:
    following the first treatment encounter/episode
  - In cases of non-treatment:
    following the last diagnostic/evaluative encounter

- If the data item *Readmission To The Same Hospital Within 30 Days of Surgical Discharge* is coded 1, 2, or 3, report *Secondary Diagnosis*ICD-10-CM codes appearing on the "readmission" discharge abstract.
- If no ICD-10-CM secondary diagnoses were documented, then code 0000000in this data item, and
  leave the remaining *Secondary Diagnosis* data items blank.
- If fewer than ten ICD-10-CMsecondary diagnoses are listed, then code the diagnoses listed,and leave the remaining *Secondary Diagnosis* data items blank.
- Allowable values are:
  0000000; all values beginning with
  A-B, E, G-P, R-S; and the following ranges:
  T36- T50996XX, Y62-Y849ZZZ, Z1401-Z229ZZZ,
  Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ.

70040 - Text Local Hospital ID

Field Length: 10

This is a calculated field which identifies the facility(ies) which entered case text. A case in a multi-facility database may be associated with more than one facility, and thus may have text for each affiliated facility.

70050-70140 - OPEN TEXT DOCUMENTATION

Field Length: 3360 (x 10)

In accordance with new CDC/NPCR requirements, KCR began requiring text documentation on all new cases diagnosed January 1, 2001 and after. The documentation must include explanations regarding the history and physical, diagnostic procedures, surgeries performed surgical findings and place of diagnosis.

Text is needed to justify codes selected for specific data elements and to allow for the recording of information that is not coded at all. It is used by the central registry for quality control of the data and to assure that the data meets the standards of ACoS, NAACCR, NCDB, SEER, and NPCR.

It also is utilized to answer questions which arise during the editing and consolidation process performed at the central registry, thus improving the accuracy and timeliness of that process as well. The best code(s) from all sources can generally be selected when the supporting text is sufficient to help verify the decision.

Through more complete documentation in the text fields, it is expected that fewer cases will need to be returned to the hospital for further review and/or clarification and that error rates in data abstraction will be reduced.

TEXT FIELDS

Field	Description
70050	History and Physical
70060	X-rays/Scans/Ultrasounds
70070	Scopes/Endoscopic Exams
70080	Laboratory Tests/Markers
70090	Operative Reports
70100	Pathology Reports
70110	Site Text
70120	Histology Text
70130	Staging: CS/Summary/TNM
70135	Treatment Plan

70140	Miscellaneous/General Remarks

GENERAL INSTRUCTIONS

1. Select the category from the previous page which is the most logical to you in recording the required information. Record the information only one time even though multiple categories may apply. As an alternative, all information may be documented in the Miscellaneous/General Text field. The information, however, will need to be labeled with the appropriate text field heading.

2. Be brief. Don't record in full sentences.

3. Use standard medical abbreviations (see APPENDIX I) when possible to save space, i.e., CXR-chest x-ray; LN-lymph node; LAD-lymphadenopathy.

4. Record text information on all analytic cases. For non-analytic cases, record all dates and cancer directed therapies regardless of where received at a minimum.

5. Record exact terminology from the source document to justify your codes. Be certain to include ambiguous terminology where pertinent to the information coded, i.e., "most likely" primary lung cancer.

6. Document both positive and negative findings, i.e., H & P: peau d'orange skin; CT: neg LAD.

7. Enter in chronological order the results of diagnostic examinations and cancer directed surgeries. Record the date first, then name of procedure, the results and pertinent information. (New in NAACCR)

8. Enter additional staging information in the Staging Text field that is not documented in the other text fields.

9. Record in the Miscellaneous/General Text fields information that is overflow from a more specific text field and other pertinent information for which there is no designated field. For overflow information, indicate the name of the field being extended and then the additional pertinent information.

10. Date the open text entries in the Miscellaneous/General Text field at the beginning of the entry, including the month and year only. Record your initials at the end of the entry.

Specific Data Item Instructions

Document the following information as indicated in an appropriate text field category.

1. Sequence Number

   Note any history of a previous cancer with emphasis on the most specific site identified and the laterality when multiple primaries involve paired organs. Record date previous cancer diagnosed. Indicate if estimated.

2. Topography
   - Document the exact anatomic location of the primary tumor including lobe, quadrant, etc. as well as laterality if a paired organ.
   - Include any ambiguous terminology used to describe the primary site.
   - Record statements that rule out specific sites when patient has multiple cases of cancer, one of which is an unknown primary.
   - Note unusual topography/histology combinations (i.e., pathologist's diagnosis is endometrioid cancer of uterus - ICD-O-3 shows C56.9 ovary).

3. Histology and Grade
   - Record the exact wording used in the Final Pathologic Diagnosis on the pathology report to support the histology code.
   - If the final histologic diagnosis is an NOS term and a more definitive histology is found in the body of the report or in a special NOTE or COMMENT section, indicate from which section the histologic diagnosis was coded.
   - When a more definitive diagnosis is obtained from a supplementary document such as an immunohistochemistry report or pathologic consultation, note the source document name which provides the final diagnosis.
   - Specify the tumor grade exactly as recorded on the pathology report, i.e., II/III (new in NAACCR).

4. Diagnosis Date
   - Document the date, place, source document, and exact wording of the first occurrence of a positive cancer diagnosis. Remember to include any ambiguous terms used in making the diagnosis.
   - Record the age at diagnosis

5. Diagnostic Confirmation
   - Explain when codes 6, 7 or 8 are utilized, i.e., patient refused further workup. Remember the confirmation field covers the entire history of the patient's cancer from diagnosis to death and should be updated to a lower code whenever appropriate.

6. Tumor Size
   - Document source of the most definitive size. See *Collaborative Staging Manual and Coding Instructions* or EOD (for pre-2004 cases) for priority of documents to use in coding this element.

- Record all dimensions of the primary tumor; specify the unit of measure given including comparative descriptions such as "golf ball-sized" if applicable.
- Note such descriptions as diffuse, widespread, entire circumference.
- Document instances where a tumor contains both invasive and in-situ components and only the size of the entire lesion is noted.

7. Collaborative Staging items

SEER Extent of Disease (for pre-2004 cases)

TNM Classification & Grouping

- Record date, name of exam and any positive or negative findings which support the extent of disease coded for each of the staging systems above. Enter details regarding direct extension to other organs or structures, presence of satellite lesions/nodules and location. Be sure to include any ambiguous terminology used to indicate a positive finding.
- Note disagreement with TNM staging between registrar and physician.
- Document abstracting "rules" when pertinent, i.e., TNM chapter does not include sarcomas.
- Enter notation when staging supplied by another facility’s registrar/doctor.

8. Regional Nodes Positive and Examined

- List exact name(s) of lymph nodes and corresponding number removed from pathology report. Include information regarding laterality of nodes involved.

9. Surgery at Primary Site

- Enter the exact wording of the operative procedure performed. Include names of all organs removed "en bloc" and specify as such.

10. Surgical Margins

- Document the exact wording from the path report which supports the code selected. Indicate whether this represents a gross or microscopic description.

11. Scope of Regional Lymph Node Surgery

- List date, exact name(s) of lymph nodes, corresponding number removed and laterality for each separate surgical procedure performed.

12. Surgery at Regional/Distant Sites

- Record the specific organs/tissues removed (partial or total) during the surgical procedure.

13. Chemotherapy Code

- Note the exact names of agents administered.

14. Other Therapy Codes

- Describe in words the procedures performed and/or drugs utilized.

15. Date of Last Contact or Death
    - Document source of date of death, i.e., obituaries, expired at your facility, quarterly death list, Social Security Death Index (SSDI), KCR Vital Status Report, other health care facility.

16. General Remarks
    - Note any and all changes requested by KCR, including the date of the request or the name and date of the document from KCR which requests the change.
    - Explain any unusual circumstances which impacted the manner in which the case was coded, i.e., an unusual primary site for a particular histologic type verified by an outside institution, i.e., the Armed Forces Institute of Pathology (AFIP).
    - Enter reason why no therapy administered if known.
    - Should patient refuse further therapy, document therapy type and refusal.
    - Specify any dates which are estimated.
    - Record recommended treatment(s), that is, unknown if given.
    - Indicate information which has been coded from a source other than the medical record and what the source was, i.e., verbal information from another registrar.

70150 - LAST MODIFICATION BY

Field Length: 8

The user name of the person who last edited the case text is recorded by the computer in this field.

70160 - LAST MODIFICATION TIME

Field Length: 19

The computer automatically records the date and time the case text was edited. This field is updated each time the text is edited.

Class Data

40040 - Hospital Medical Record Number (Class)

Field Length: 15

This field records the patient's medical record number at the reporting facility. It is stored with the patient's class history. A patient record which is associated with multiple facilities may thus have a unique medical record number corresponding to each facility.

40050 - Class Local Hospital ID

Field Length: 10

This is a unique code which represents the facility reporting the case. A case in a multi-facility database may be associated with more than one registry, and this field exists in the class history record for each affiliated facility. This field is automatically coded when a facility creates or associates itself with a case, and is filled in with the facility's FIN number.

40060- 40070 - REGISTRY ACCESSION YEAR AND NUMBER (Class)

Field Length: 9

This field provides a unique identifier for the patient and consists of the year in which the patient was first seen at the reporting facility and the consecutive order in which the case was abstracted.

The first four numbers specify the year and the last five numbers are the numeric order in which the patient was entered into the registry database. A patient's accession number is never reassigned.

A case in a multi-facility database may be associated with more than one facility, and this field exists in the class history record for each affiliated facility. When a facility creates or associates itself with a case, this field is automatically filled in with the facility's Registry Accession Year and Number (items 30320 - 30330).

40080 - Class of Case (Class)

Field Length: 2

Class of case reflects the facility's role in managing this cancer, whether the cancer is required to be reported to ACoS by approved facilities, and whether the case was diagnosed after the program's reference date. Enter the two digit code that describes the patient's relationship to the facility.

Instructions for Coding

- Code 00 applies only when it is known that the patient went elsewhere for treatment. If that information is not available, code class of case '10.' It is possible that information for coding class of case will change during the patient's first course of care. If that occurs, edit the code accordingly.
- ACoS approved facilities should document Institution Referred To (item #31660) for patients coded 00 to establish that the patient went elsewhere for treatment.
- A staff physician (codes 10-12, 41) is a physician who is employed by the reporting facility, under contract with it, or who has routine practice privileges there.
- Refer to the "Case Reporting Requirements" section of this manual for a discussion of Classes and KCR requirements.

Codes

Analytic Classes of Case (Required by CoC to be abstracted by accredited programs)	
	Initial diagnosis at reporting facility
00	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
10	Initial diagnosis at the reporting facility or in a staff physician's office AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS
11	Initial diagnosis in staff physician's office AND part of first course treatment was done at the reporting facility
12	Initial diagnosis in staff physician's office AND all first course treatment or decision not to treat was done at the reporting facility
13	Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility
14	Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility
	Initial diagnosis elsewhere
20	Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS
21	Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility
22	Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility

Non-analytic Classes of Case (Not required by CoC to be abstracted by accredited programs, but may be required by KCR)	
	Patient appears in person at reporting facility
30	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (i.e., consult only or staging workup)
31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care
32	Diagnosis AND all first course treatment provided elsewhere AND patients presents at reporting facility with disease recurrence or persistence
33	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only
34	Type of case not required by CoC to be accessioned (i.e., CIS of cervix) AND initial diagnosis AND part or all of first course treatment by reporting facility
35	Case diagnosed before program's reference date AND initial diagnosis AND all or part of first course treatment by reporting facility
36	Type of case not required by CoC to be accessioned (i.e., a basal cell skin cancer) AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility
37	Case diagnosed before program's reference date AND initial diagnosis elsewhere AND all or part of first course treatment by facility
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death
	Patient does not appear in person at reporting facility *D***o not abstract cases in class 40 - 99- refer them to KCR; these classes are for KCR use only**
40	Diagnosis AND all first course treatment given at the same staff physician's office
41	Diagnosis and all first course treatment given in two or more different staff physician offices
42	Nonstaff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (i.e., hospital abstracts cases from an independent radiation facility)
43	Pathology or other lab specimens only
49	Death certificate only
98	Non-hospital treatment abstracted by KCR
99	Non-hospital cases abstracted by KCR

A case in a multi-facility database may be associated with more than one facility, and this field exists in the class history record for each affiliated facility. When a facility creates or associates itself with a case, this field is automatically filled in with the facility's Class of Case (item 30140).

40081 - Date of First Contact (Class)

Field Length: 8

This is the date the patient had initial contact with the facility as either an inpatient or outpatient for diagnosis and/or treatment of a reportable tumor. For autopsy-only or DCO cases, use the date of death. When a patient is diagnosed in a staff physician's office, the date of first contact is the date the patient was physically first seen at the reporting facility.

A case in a multi-facility database may be associated with more than one facility, and this field exists in the class history record for each affiliated facility. When a facility creates or associates itself with a case, this field is automatically filled in with the facility's Date of First Contact (item 30150).

40082 - Institution Referred From (Class)

Field Length: 10

This field identifies the facility that referred the patient to the reporting facility. Enter the FIN of the facility that referred the patient to your institution, or use one of the special codes below.

0000000000	The patient was not referred to the reporting facility from another facility
9999999999	The patient was referred, but the referring facility's ID number is unknown

A case in a multi-facility database may be associated with more than one facility, and this field exists in the class history record for each affiliated facility. When a facility creates or associates itself with a case, this field is automatically filled in with the value from Institution Referred From (item 31650).

40083 - Institution Referred To (Class)

Field Length: 10

This field identifies the facility to which the patient was referred for further care after discharge from the reporting facility. Enter the FIN of the facility to which the patient was referred, or use one of the special codes below.

0000000000 The patient was not referred to another facility
9999999999 The patient was referred to another facility, but the facility's ID number is unknown

A case in a multi-facility database may be associated with more than one facility, and this field exists in the class history record for each affiliated facility. When a facility creates or associates itself with a case, this field is automatically filled in with the value from Institution Referred To (item 31660).

40084 - Palliative Procedure - This Facility (Class)

Field Length: 1

This field allows reporting facilities to track care that is considered palliative rather than diagnostic or curative in intent. Palliative procedures are performed to relieve symptoms and may include surgery, radiation therapy, systemic therapy, and/or pain management therapy.

Surgical procedures, radiation therapy, or systemic therapy provided to prolong the patient's life by controlling symptoms, to alleviate pain, or to make the patient comfortable should be coded as palliative care and as first course therapy if that procedure removes or modifies malignant tissue.

Code	Description
0	No palliative care provided. Diagnosed at autopsy.
1	Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt is made to diagnose, stage, or treat the primary tumor.
2	Radiation therapy to alleviate symptoms, but no attempt is made to diagnose, stage, or treat the primary tumor.
3	Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt is made to diagnose, stage, or treat the primary tumor.
4	Patient received or was referred for pain management therapy with no other palliative care.
5	Any combination of codes 1, 2, and/or 3 without code 4.
6	Any combination of codes 1, 2, and/or 3 with code 4.
7	Palliative care was performed or referred, but no information on the type of procedure is available. Palliative care was provided that does not fit the descriptions for codes 1-6.
9	It is unknown if palliative care was performed or referred; not stated in patient record.

A case in a multi-facility database may be associated with more than one facility, and this field exists in the class history record for each affiliated facility. When a facility creates or associates itself with a case, this field is automatically filled in with the value from Palliative Procedure At This Facility (item 31680).

40085 - Abstracted By (Class)

Field Length: 3

The field records the initials or assigned code of the registrar who abstracted the case. A case in a multi-facility database may be associated with more than one facility, and this field exists in the class history record for each affiliated facility. When a facility creates or associates itself with a case, this field is automatically filled in with the value from Abstracted By (item 31140).

40086 - Archive FIN (Class)

Field Length: 10

This field identifies the CoC Facility Identification Number (FIN) of the facility at the time it originally accessioned the case.

When a CoC approved facility merges with another facility or joins a network, its unique FIN may change. Archive FIN preserves the identity of the facility at the time the case was initially accessioned so that records resubmitted subsequent to such a reorganization can be recognized as belonging to the same facility.

Archive FIN is automatically coded by CPDMS.net. This item never changes and must be included as part of the patient record when data are submitted to the NCDB. For facilities that have not merged, Archive FIN and FIN are the same.

A case in a multi-facility database may be associated with more than one facility, and this field exists in the class history record for each affiliated facility. When a facility creates or associates itself with a case, this field is automatically filled in with the value from Archive FIN (item 31725).

40088 - Patient Accession Number (Class)

Field Length: 10

A unique accession number is assigned to each patient for each reporting institution affiliated with the patient. The accession number identifies the patient even if multiple primaries exist. The first four digits of the accession number specify the year in which the patient was first seen at the reporting institution for the diagnosis and/or treatment of cancer. The last six numbers are the numerical order the reporting institution entered their first reportable case of this patient into the registry's database.

The computer calculates these fields by copying in the accession number of the first abstracted case entered by each reporting institution for this patient.

A case in a multi-facility database may be associated with more than one facility, and this field exists in the class history record for each affiliated facility. When a facility owns the case, this field is automatically filled in with the value from Patient Accession Number (item 31721).

40089 - Date Case Completed - COC

Field Length: 8

This is a calculated data item which identifies the date that specified items are completed and pass relevant edits, based on the Class of Case (item #30140). This field is used to evaluate compliance by ACoS-approved facilities with Standard 3.3, which specifies that 90% of cases must be completed within six months of the patient's first contact with the facility. It should not be confused with Date Case Completed (item #31410). This field will be blank for cases diagnosed prior to January 1, 2010.

Class of Case	Description	Items That Must Be Completed by Date Case Completed - COC
00-22	All analytic cases	Identification, demographics, diagnostic
10-22	Patient received part or all first course treatment from facility	Staging, hospital-specific treatment
10, 12, 14, 20, 22	Patient received all first course treatment from facility, or unspecified whether all or part	Summary treatment (treatment at any facility)
00	Patient diagnosed at facility, received all treatment elsewhere	Facility referred to OR a treating physician
20-22	Patient diagnosed elsewhere, received part or all of treatment from facility	Facility referred from OR the managing physician

A case in a multi-facility database may be associated with more than one facility, and this field exists in the class history record for each affiliated facility. When a facility creates or associates itself with a case, this field is automatically filled in with the value from Date Case Completed - COC (item #31405).

40090 - Date Class History Completed

Field Length: 8

This field records the date that the case was initially saved without errors by each facility affiliated with a case. It is automatically calculated.

40100 - Date Class History Last Updated

Field Length: 8

The field records the date the class history was last changed or updated. It is automatically calculated any time the class history is edited.

40115 – Import Reporting Facility (Class)

Field length: 10

This is a unique code to KCR which represents the facility reporting the case to an out-of-state central registry, such as the Ohio State Cancer Registry or the Veterans Affairs Central Cancer Registry, and then imported into a CPDMS database. A case in a multi-facility database may be associated with more than one registry, and this field exists in the class history record for each affiliated facility. This field is automatically coded when an OSDE or VA Central file is imported, and is filled in with the facility's FIN number as contained in the NAACCR import file.

40360 - LAST MODIFICATION BY (Class)

Field Length: 8

This is a calculated field which records the user name of the last individual to modify class history data. It is updated each time the record is edited.

40370 - LAST MODIFICATION TIME (Class)

Field Length: 19

This field automatically records the date and time that class history data was last modified.

Therapy Data

THERAPY INFORMATION

Data items 50040-50400

Each type of definitive therapy (surgery, radiation, chemotherapy, etc.) that the patient received should be recorded in detail in data items 50040-50400. These items may be repeated as often as necessary in order to record every type of treatment administered to the patient. If the same type of treatment is given more than once during a course, it only needs to be recorded one time -- UNLESS the procedure code or treatment agents change. Then, items 50040-50400 would have to be repeated in order to record the differences in those item(s). For example, if a patient has both a lumpectomy and a mastectomy, you would have to complete items 50040-50400 for each instance of surgery because the procedure code is different. *See special note for radiation treatment below*.

Coding Surgery: The CPDMS software uses the same data fields (items 50040-50400) to record both definitive and non-definitive therapies. Non-definitive surgical procedures include incisional biopsies, bypass surgeries, etc., and the codes for these procedures are the same for all types of cancer. Coding non-definitive surgical procedures became required by the ACoS for approved facilities in 1996. Beginning with 2010 diagnoses, KCR requires the first non-definitive surgical procedure which is positive for malignancy to be recorded.

The definitive surgical procedure codes are site specific and they are contained in Appendix G. These surgery codes changed significantly in 1998 with the ACoS ROADS Manual, and again in 2003 with the FORDS Manual. Surgery codes collected prior to 1998 were converted to the 1998 ROADS definitions and are stored in data items 50240-50290. Surgeries coded for cancers diagnosed from 1998 to 2002 are also collected in items 50240-50290 and are defined by the ACoS ROADS Manual. Starting with cancers diagnosed in 2003, the site specific surgery codes are stored in data items 50100-50120 and are defined by the ACoS FORDS Manual. Both sets of codes are included in Appendix G. ***Be sure to use the correct table based on the diagnosis year of the cancer being abstracted.***

Note on Coding Radiation Treatment: (This is for ACoS approved hospitals and pertains to treatment given to patients diagnosed after January 1, 2003.) You should summarize the entire first course of radiation treatment on one radiation therapy segment. Code all eight new radiation fields implemented with FORDS. If you learn of more radiation given after you have abstracted and entered this patient record, then EDIT the EXISTING radiation treatment segment instead of creating a new radiation therapy record segment. This is important for NCDB submissions. They require one summary record of first course radiation treatment. If there are more in your database, only the one with the earliest start date will be sent to NCDB. If palliative radiation is also given, it must also be recorded in the radiation therapy fields. Each data element and the appropriate codes are further explained on the following pages. Follow-up information about subsequent therapies may be recorded in the same manner as the first course of therapy.

50040 - THERAPY TYPE

Field Length: 1

Using the codes below, record the type of therapy the patient received, regardless of where it was given.

THERAPY TYPES

Code	Description
N	Non-definitive surgery
S	Surgery
R	Radiotherapy
C	Chemotherapy
H	Hormone therapy
I	Immunotherapy
T	Transplant or Endocrine procedures
O	Other therapy

Other therapy includes: experimental, alternative, complementary, and any other types of therapy not elsewhere listed.

If no definitive therapy was administered to this patient, or you may leave items 50040-50400 blank and record an appropriate code in Reason No Therapy and Date No First Therapy.

50050 - COURSE OF THERAPY

Field Length: 1

Enter the letter which indicates whether this therapy type was administered as part of the first course of therapy or was part of a subsequent course of therapy.

Code	Description
F	First course
S	Subsequent

Refer to the General Coding Principals section of this manual for a discussion of the definition of first course of therapy.

50060 - DATE THERAPY STARTED

Field Length: 8

Enter the month, day, and year this treatment type was initiated for this case of cancer.

50070 - Therapy Facility

Field Length: 10

Enter the name or code of the facility where treatment was given. These codes are optional and defined by each institution, for its own use. The codes for many health care facilities in Kentucky listed in Appendix F may be used.

50075 - THERAPY LOCAL HOSPITAL ID

Field Length: 10

Select the appropriate code to indicate if this therapy was administered at your facility. Otherwise, enter '0' for No.

Code	Description
0	Not administered by this facility
<hosp ID>	<HOSPITAL NAME>
9	Valid only for diagnoses before 1/1/2003

50090 - Non-definitive Surgery

Field Length: 2

When therapy type = N, you may record surgical procedures that are NOT considered treatment in this field. The codes are the same for all sites:

Code	Description
01	Incisional biopsy of other than primary site leaving gross residual disease. Needle biopsy of other than primary site
02	Incisional biopsy of primary site leaving gross residual disease. Needle biopsy of primary site
03	Exploratory ONLY (no biopsy)
04	Bypass surgery (no biopsy); - ostomy ONLY (no biopsy)
05	Exploratory ONLY and incisional or needle biopsy of primary site or other sites
06	Bypass surgery and incisional or needle biopsy of primary site or other sites - ostomy ONLY and incisional or needle biopsy of primary site or other sites
07	Non-definitive surgery, NOS

- Record the type of procedure performed as part of the initial diagnosis and workup, whether this is done at your institution or another facility.
- If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, use code 02 (Incisional biopsy of primary site).
- For lymphomas of lymph node primary site (C77._), you may code the excision of a lymph node in this item (code 02) if it is for diagnostic and/or staging purposes. The surgical removal of lymph nodes for eradication of the lymphoma would be coded in Surgical Procedure of Primary Site.
- Do not code surgical procedures which aspirate, biopsy, or remove **regional lymph nodes** in an effort to diagnose and/or stage disease in this data item. Use the data item *Scope of Regional Lymph Node Surgery* to code these procedures.
- Do not code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears). These are not considered surgical procedures.
- Do not code excisional biopsies with clear or microscopic margins in this data item. Use the data item *Surgical Procedure of Primary Site*.
- If a needle biopsy precedes an excisional biopsy, *even if no tumor is found at the time of surgery*, both the needle biopsy and surgery must be recorded. Code the needle biopsy in the Non-definitive surgery field and code the excision in the Surgery at Primary Site. Surgical margins must be evaluated in order to determine if a biopsy is incisional or excisional; and margins cannot be evaluated for a needle biopsy.

- Do not code palliative surgical procedures in this data item. Use the data item *Palliative Procedure*.
- Do not record biopsies that are negative for cancer.

50100 - SURGICAL PROCEDURE OF PRIMARY SITE-FORDS

Field Length: 2

Record the surgical procedure(s) performed to the primary site.

- Site-specific codes for this data item are found in Appendix G- Surgery Codes-FORDS.
- For codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is unavailable.
- Biopsies that remove all of the tumor and/or leave only microscopic margins are to be coded in this item, even if documented as "incisional biopsy."
- Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site, except where noted in Appendix G-Surgery Codes-FORDS.
- If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, then code the total or final results.
- For all hematopoietic, reticuloendothelial, immunoproliferative, and myeloproliferative diseases, this code is 98. Any surgical procedures performed for these diagnoses are recorded in the data item Surgical Procedure Other Site-FORDS.

50110 - SCOPE OF REGIONAL LYMPH NODE SURGERY-FORDS

Field Length: 1

Record the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event.

- The scope of regional lymph node surgery is collected for each surgical event even if surgery of the primary site was not performed.
- Record surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data item.
- Codes 0-7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
- For primaries of the meninges, brain, spinal cord, cranial nerves, and other parts of the central nervous system (C70.0-C70.9, C71.0-C71.9, C72.0-C72.9), code 9.
- For lymphomas (M-9590-9596, 9650-9719, 9727-9729) with a lymph node primary site (C77.0-C77.9), code 9.
- For an unknown or ill-defined primary (C76.0-C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989), code 9.
- Do not code *distant* lymph nodes removed during surgery to the primary site for this data item. Distant nodes are coded in the data field *Surgical Procedure/Other Site.*
- Refer to the current AJCC *Cancer Staging Manual* for site-specific identification of regional lymph nodes.
- If the operative report lists a lymph node dissection, but no nodes were found by the pathologist, code this field 0 (no lymph nodes removed).
- If the patient has two primaries with common regional lymph nodes, code the removal of regional nodes for both primaries.

Code	Label	Description
0	None	No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy
1	Biopsy or aspiration of regional lymph node, NOS	Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement of disease.
2	Sentinel lymph node biospy	Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.
3	Number of regional nodes removed unknown or not stated; regional	Sampling or dissection of regional lymph node(s) and the number of nodes removed is unknown or not states. The procedure is not specified as sentinel nodes node biopsy.

	lymph nodes removed, NOS	
4	1-3 regional lymph nodes removed	Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
5	4 or more regional lymph nodes removed	Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
6	Sentinel node biopsy and code 3, 4, or 5, at same time, or timing not stated	Code 2 was performed in a single surgical event with code 3, 4, or 5. Or, code 2 and 3, 4, or 5 were performed, but timing was not stated in patient record.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	Code 2 was followed in a subsequent surgical event by procedures coded 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; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

50120 - SURGICAL PROCEDURE/OTHER SITE-FORDS

Field Length: 1

Record the surgical removal of *distant lymph nodes* or other tissue(s)/organ(s) beyond the primary site.

- Assign the highest numbered code that describes the surgical resection of *distant lymph node(s)* and/or regional/distant tissue or organs.
- Incidental removal of tissue or organs is not a "Surgical Procedure/Other Site."
- Code 1 if any surgery is performed to treat tumors of unknown or ill-defined primary sites (C76.0-C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989).

Code	Description
0	No surgical procedure of nonprimary site was performed.
1	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
3	Nonprimary surgical procedure to *distant lymph node(s)*
4	Nonprimary surgical procedure to distant site
5	Any combination of surgical procedures 2, 3, or 4.
9	Unknown; death certificate only

50130 - SURGICAL MARGINS

Field Length: 1

This field describes the status of the surgical margins after resection of the primary tumor. The codes for surgical margins are not site specific and were converted for cancers diagnosed before 2003.

Microscopic involvement cannot be seen by the naked eye. The pathology report usually documents microscopic involvement in the final diagnosis or the microscopic portion of the report.

Macroscopic involvement is gross tumor which is visible to the naked eye. It may be documented in the operative report or in the gross portion of the pathology report.

The code is hierarchical; if two codes describe the margin status, use the numerically higher code.

Code the margin status for each individual surgical event.

- If no surgery of the primary site was performed, code 8.
- For lymphomas (M-9590-9596, 9650-9719, 9727-9729) with a lymph node primary site (C77.0-C77.9), code 9.
- For an unknown or ill-defined primary (C76.0-C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4, or M-9750, 9760-9764, 9800-99820, 9826, 9831-9920, 9931-9964, 9980-9989), code 9.
    - Code 9 if the pathology report makes no mention of margins or no tissue was sent to pathology.

Code	Label	Description
0	No residual tumor	All margins are grossly and microscopically negative
1	Residual tumor, NOS	Involvement is indicated, but not otherwise specified.
2	Microscopic residual tumor	Cannot be seen by the naked eye.
3	Macroscopic residual tumor	Gross tumor of the primary site which is visible to the naked eye.
7	Margins not evaluable	Cannot be assessed (indeterminate).

8	No primary site surgery	No surgical procedure of the primary site. Diagnosed at autopsy.
9	Unknown or not applicable	Unknown whether a surgical procedure to the primary site was performed; DCO; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic diseases.

50135 - SURGICAL APPROACH 2010

Field Length: 1

This item is used to describe the surgical method used to approach the primary site for patients undergoing surgery of the primary site. It should not be confused with the obsolete field "Surgical Approach (ROADS)" (item #50240).

Instructions for Coding

- This item may be left blank for cases diagnosed prior to January 1, 2010.
- Assign code 2 or 4 if the surgery began as robotic assisted or endoscopic and was converted to open.
- If both robotic and endoscopic surgery were used, code to robotic (codes 1 or 2).
- For ablation procedures, assign code 3.

Code	Description
0	No surgical procedure of primary site at this facility; Diagnosed at autopsy
1	Robotic assisted
2	Robotic converted to open
3	Endoscopic or laparoscopic
4	Endoscopic converted to open
5	Open or approach unspecified
9	Unknown whether surgery was performed at this facility

50140 - RADIATION THERAPY CODE

Field Length: 1

Code the type of radiation therapy that the patient received. This field will be calculated for ACoS approved facilities from items 50320 and 50340. Non-approved facilities MUST enter the radiation therapy code manually.

For all sites, the codes are:

Code	Description
1	Beam radiation
2	Radioactive Implants
3	Radioisotopes
4	Combinations of beam radiation with radioactive implants or radioisotopes
5	Radiation therapy, NOS

Code 1 (beam radiation) includes treatment given with X ray, cobalt, linear accelerator, neutron beam, intensity modulated radiation therapy (IMRT), and betatron, as well as spray radiation and stereotactic radiosurgery, such as gamma knife and proton beam, regardless of the source of the radiation.

Code 2 (radioactive implants) includes brachytherapy, radioembolization, interstitial implants, molds, seeds, needles, or intracavity applicators of radioactive materials, such as cesium, radium, radon, and radioactive gold.

Code 3 (radioisotopes) includes internal use of radioactive isotopes, such as iodine-131 or phosphorus-32, given orally or intracavitarily, or by intravenous injection.

If the method or source is not given, code 5 (radiation therapy, NOS).

50150-50170 - Radiation Sites

Field Length: 2 (x3)

When the treatment type is R, record a two digit code for up to three sites to which radiotherapy was directed. Use the General Sites Dictionary in Appendix E. When more than three sites are indicated, enter the code for the three most definitive sites, coding the primary site of the cancer in the first set of boxes.

Precede any single digit codes with a zero.

50180 - Total Number of Rads

Field Length: 5

Enter the total dosage of radiation, directed to the site specified in items 50150-50170, that was received by the patient for this particular type and course of radiation therapy.

50190 - CHEMOTHERAPY CODE

Field Length: 1

Code the type of chemotherapy that the patient received. Refer to the SEER*Rx Interactive Drug Database for a list of chemotherapeutic agents.

For all sites, the codes are:

Code	Description
1	Chemotherapy, NOS
2	Chemotherapy, single agent
3	Chemotherapy, multiple agents (combination regimens)

Record any chemical that is administered to treat cancer tissue that is not considered to achieve its effect through a change in the hormonal balance. Only the agent is coded, not the method of drug administration (i.e., chemoembolization). One planned course of chemotherapy may be given in multiple segments or cycles (i.e., CHOP x 6). Record as a single course of therapy.

If the patient has an adverse reaction to a particular chemotherapeutic drug, the physician may substitute another If the replacement drug belongs to the **same** group as the original drug, it is considered to be the same regimen for coding purposes. If the replacement drug is in a **different** group than the original drug, code as a new course of therapy.

Two or more single agents given at separate times during the first course of cancer-directed therapy are considered a combination regimen and coded 3 (chemotherapy, multiple agents). If an agent in a combination regimen is a hormone (such as Prednisone in CHOP), code '3' here and record the hormonal agent again, under Hormone therapy.

When chemotherapeutic agents are used as radiosensitizers or radioprotectants, they are given at a much lower dosage and do not affect the cancer. Radiosensitizers and radioprotectants are classified as ancillary drugs. Do not code as chemotherapy.

Effective with diagnoses in 2005 and later, use the SEER Rx program for a list of all cancer therapeutic agents (available from SEER's web site: http://seer.cancer.gov/tools/seerrx/.) For pre-2005 cases, refer to Appendix H and/or the SEER Program Self-Instructional Manual for Tumor Registrars, Book 8, Antineoplastic Drugs Second Edition.

50200 - HORMONE THERAPY

Field Length: 1

Record '1' if hormone treatment agents were administered as first course treatment at this or any other facilities.

- Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).
- Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment. For example, a patient has advanced lung cancer with multiple metastases to the brain. The physician orders Decadron to reduce the edema in the brain and relieve the neurological symptons. Decadron is not coded as hormone therapy. Or, a patient with advanced disease is given Prednisone to stimulate the appetite and improve nutritional status. Do not code the Prednisone as hormone therapy.
- Some types of cancers are **slowed** or **suppressed** by **hormones**. These cancers are treated by administering hormones.
  Example 1: Endometrial cancer may be treated with progesterone. Code all administration of progesterone to patients with endometrial cancer in this field. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer.
  Example 2: **Follicular and papillary cell** cancers of the **thyroid** are often treated with thyroid hormone to suppress serum thyroid-stimulating hormone (TSH). If a patient with follicular cell-derived cancer of the thyroid (8260, 8330, 8331, 8332, 8335, 8340, or 8346) is given a thyroid hormone, code the treatment in this field.
- Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy, except for thyroid replacement therapy, as described above.
- Use the SEER Rx program (available from web site: http://seer.cancer.gov/tools/seerrx/) to identify hormonal agents. For pre-2005 diagnoses, refer to Appendix H and to the *Self-Instructional Manual for Tumor Registrars: Book 8 - Antineoplastic Drugs*, Third Edition.
- Code surgery or radiation given **for hormonal effect** under Transplant/Endocrine Procedures (Item # 50220).

50210 - IMMUNOTHERAPY

Field Length: 1

Record '1' if immunotherapy was administered as first course treatment at this or any other facilities. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

Types of immunotherapy

Cancer Vaccines: Cancer vaccines are still in the experimental phase and are not coded in this data item. They may be coded in the field Other Therapy. Currently clinical trials use cancer vaccines for brain, breast, colon, kidney, lung, melanoma and ovary.

Interferons: Interferons belong to a group of proteins called cytokines. They are produced naturally by the white blood cells in the body. Interferon-alpha is able to slow tumor growth directly as well as activate the immune system. It is used for a number of cancers including multiple myeloma, chronic myelogenous leukemia (CML), hairy cell leukemia, and malignant melanoma.

Interleukins (IL-2) are often used to treat kidney cancer and melanoma.

Monoclonal Antibodies: Prior to 2005, monoclonal antibodies were coded as immunotherapy. Monoclonal antibodies are produced in a laboratory. The artificial antibodies are injected into the patient to seek out and disrupt cancer cell activities and to enhance the immune response against the cancer. For example, Rituximab (Rituxan) may be used for non-Hodgkin lymphoma, and trastuzumab (Herceptin) may be used for certain breast cancers.

With the introduction of SEER Rx in 2005 for coding systemic therapy, monoclonal antibodies are coded as chemotherapy if they act as cytostatic agents (such as Rituxan and Herceptin) or as radioisotopes if they deliver cytotoxic radioisotopes to the cells (such as Bexxar and Zevalin).

Effective with diagnoses in 2005 and later, use the SEER Rx program (available from web site: http://seer.cancer.gov/tools/seerrx/) to identify immunotherapeutic agents. For pre-2005 cases, refer to Appendix H and to the *Self-Instructional Manual for Tumor Registrars: Book 8 - Antineoplastic Drugs*, Third Edition.

50220 - HEMATOLOGIC TRANSPLANT AND ENDOCRINE PROCEDURES

Field Length: 2

Record any systemic therapeutic *procedures* administered as part of the first course of treatment at this and all other facilities. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.

Instructions for Coding

- Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow donated by a person other than the patient). For cases in which the bone marrow transplant was syngeneic (transplanted marrow from an identical twin), the item is coded as allogeneic.
- Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.
- Endocrine irradiation and/or endocrine surgery are procedures which suppress the naturally occurring hormonal activity of the patient and thus alter or effect the long-term control of the cancer's growth. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.

Code	Description
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.)

50230 - OTHER THERAPY CODE

Field Length: 1

These codes are available for any 'other' treatment received by the patient-- other than surgery, chemotherapy, radiation therapy, hormone therapy, immunotherapy, transplants or endocrine procedures.

Code 0 indicates nonsurgical types of non-definitive treatment. These are optional and do not have to be recorded. Ancillary drugs such as allopurinol, growth stimulating factors (i.e., Neupogen and Epogen) and antibiotics for MALT lymphoma are examples of non-definitive therapy.

Code	Label	Description
0	Non- cancer directed treatment	OPTIONAL CODE - may be used to record ancillary drugs, supportive care, stent placement, etc.
1	Other treatment	Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic). Examples include treatment unique to hematopoietic diseases (see Notes below), tumor embolization which does not involve a chemotherapy or radiotherapy agent (i.e., when alcohol is used as the embolizing agent in head and neck cancers), photophoresis for thin melanomas or for mycosis fungoides, and PUVA (psoralen and long-wave ultraviolet radiation).
2	Other - Experimental	This code is not defined. It may be used to record participation in institution-based clinical trials. Gene therapy is coded 2.
3	Other - Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other - Unproven	Unconventional therapies; alternative and complementary therapies (see below).

Treatment for certain reportable hematopoietic diseases can be supportive care that does not meet the usual definition of treatment which "modifies, controls, removes, or destroys proliferating cancer tissue." Such treatments include phlebotomy, transfusions, and aspirin (see Notes below), and should be coded 1.

Notes for Hematopoietic diseases:

- The hematopoietic diseases for which transfusions may be coded as other therapy are comprised of the following histologies ONLY: 9945, 9980, 9982-9986, and 9989. Do not code transfusions as therapy for leukemias, lymphomas, or other hematopoietic histologies not on the previous list. Transfusions may include whole blood, RBCs, platelets, plateletpheresis, fresh frozen plasma (FFP), plasmapheresis, and cryoprecipitate.
- Phlebotomy may be coded as other therapy only for 9950/3, polycythemia vera. Phlebotomy may be called blood removal, blood letting, or venisection.
- Aspirin (also known as acetylsalicylic acid (ASA), or by a brand name) is coded as other therapy for 9962/3, essential thrombocythemia. Record aspirin therapy ONLY if given to thin the blood for symptomatic control of thrombocythemia. To determine whether aspirin is administered for pain, cardiovascular protection, or thinning of platelets in the blood, use the following general guideline:
  -Pain control is approximately 325-1000 mg every 3-4 hours.
  -Cardiovascular protection starts at about 160 mg/day.
  -Aspirin treatment for essential thrombocythemia is low dose, approximately 70-100 mg/day.

Use code 3 - Double blind for clinical trial before the code is broken. After the code is broken, review and re-code therapy as needed, according to the treatment actually administered.

Use code 6 - Unproven therapy - for **unconventional methods** whether they are given alone or in combination with other cancer directed treatments.

Unconventional treatment agents are:

Cancell, Carnivora, Glyoxylide, Iscador, Koch synthetic antitoxins, Krebiozen, Laetrile, Malonide, Parabenzoquinone

Use code 6 - Unproven therapy - for **alternative and complementary** therapies **ONLY if they are NOT given in combination with other cancer directed treatments.**

Alternative & Complementary Therapies are:

Alternative Systems
Acupuncture
Ayurveda
Environmental medicine
Homeopathic medicine
Natural Products
Native American, Latin American, or traditonal Oriental medicine

Bioelectromagnetic Applications
Blue light treatment

- Electroacupuncture
- Magnetoresonance spectroscopy

Diet, Nutrition, Lifestyle
- Changes in lifestyle
- Diet
- Gerson Therapy
- Macrobiotics
- Megavitamins
- Nutritional Supplements

Herbal Medicine
- Ginger
- Ginkgo Biloba extract
- Ginseng root

Manual Healing
- Acupressure
- Biofield Therapeutics
- Massage therapy
- Reflexology
- Zone therapy

Mind/Body Control
- Biofeedback
- Humor therapy
- Meditation
- Relaxation techniques
- Yoga

Pharmacological and Biological Treatments
- Anti-oxidizing agents
- Cell treatment
- Metabolic therapy
- Oxidizing agents

50240 - SURGICAL APPROACH (ROADS)

Field Length: 1

This data field applies only to cancers diagnosed before 2003. Collection of this data item was discontinued as of 1/1/2003 with FORDS implementation.

"Surgical Approach" describes the method used to approach the organ of origin and/or primary tumor. Code the approach for surgical treatments of the primary site only. If no definitive surgical procedure at the primary site was done ("Surgery of Primary Site" is coded 00), "Surgical Approach" must be coded 0.

"Endoscopy, image guided" is a generic term for guidance provided by any imaging technique include, but not limited to, CT scans, MRI scans, ultrasound, or radiographic imaging.

"Open" is a generic term describing all non-scope approaches. Procedures for which "Surgical Approach" would be coded open include, but are not limited to, mastectomy; excision of a melanoma of the skin; glossectomy.

"Open, assisted by endoscopy" means that the scope is being used (present in the body) at the same time the primary tumor is resected. DO NOT CODE a procedure as assisted by endoscopy when the scope is used and removed prior to the resection or when it is inserted and used after the resection of the primary tumor.

Example: Patient with lung cancer is taken to the surgical suite. A bronchoscopy and mediastinoscopy are done to evaluate whether the lesion is resectable. The scopes are removed before the surgeon performs a wedge resection. Code "Surgical Approach" open, NOT assisted by endoscopy.

The codes for surgical approach when Therapy type = S are site specific and they are contained in Appendix G Surgical Codes-ROADS.

50250 - SURGERY AT PRIMARY SITE (ROADS)

Field Length: 2

When therapy type = S, the Surgery at Primary Site code indicates a definitive surgical treatment for this cancer. Enter the two digit code to indicate the specific surgical procedure performed at the primary cancer site. These codes are listed in Appendix G - Surgery Codes - ROADS. They are site specific codes, as taken from the ACoS Registry Operations and Data Standards Manual, revised for 1998. This data item applies only to cancers diagnosed before 2003. (Surgeries performed on patients diagnosed after 1/1/2003 are recorded in data item 50100.)

Use the following guidelines to complete this field:

Only record surgeries of the primary site. Surgery to remove regional tissue or organs is coded in this field only if the tissue/organs are removed with the primary site as part of a specified code definition or in an **en bloc** resection. An en bloc resection is the removal of organs in one piece at one time.

Example: When a patient has a modified radical mastectomy, since the breast and axillary contents are removed in one piece (en bloc), surgery of primary site is coded as a modified radical mastectomy (50) even if the pathology finds no nodes in the specimen.

The range of codes from 10-79 are hierarchical and supersede codes '80', '90', and '99'. If more than one code describes the procedure, use the numerically higher code. If surgery was previously done, code the total result of that surgery with the current surgery. Biopsies that remove all gross tumor or leave only microscopic margins should be coded as surgery to the primary site.

If there was no surgical procedure at the primary site, code 00.

50260 - SCOPE OF REGIONAL LYMPH NODE SURGERY (ROADS)

Field Length: 1

This data field applies only to cancers diagnosed before 2003. Collection of this data item was discontinued as of 1/1/2003 with FORDS implementation.

For the majority of sites, "Scope of Regional Lymph Node Surgery" defines the removal of regional lymph node(s). This refers to the farthest regional node removed regardless of involvement with disease. There is no minimum number of nodes that must be removed. If at least one regional lymph node was removed, the code for this field must be in the range of 1-5. If a regional lymph node was aspirated or biopsied, enter code '1'.

For head and neck sites, this field describes 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.

These codes are site specific and they are contained in Appendix G - Surgery Codes - ROADS. The codes are hierarchical; if more than one applies, record the highest code (except 9). A list identifies the regional lymph nodes for each site. Any other nodes are distant; code their removal in the data field "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)". **For unknown primaries**, **leukemias, lymphomas (except lymphomas of the spleen), hematopoietic diseases, and brain primaries code '9' in this field.**

If no regional lymph nodes were removed, code 0.

Nodes which are considered regional are those defined in the AJCC *Manual for Staging of Cancer* in each site specific chapter.

50270 - NUMBER OF REGIONAL LYMPH NODES REMOVED (ROADS)

Field Length: 2

This data field applies only to cancers diagnosed before 2003. Collection of this data item was discontinued as of 1/1/2003 with FORDS implementation.

Record the number of regional lymph nodes microscopically examined in the pathology report **DURING THIS SURGICAL PROCEDURE ONLY. DO NOT** add numbers of nodes removed at different surgical events.

If no regional lymph nodes are identified in the pathology report, code 00 even if the surgical procedure includes a lymph node dissection (i.e., modified radical mastectomy) or even if the operative report documents removal of nodes.

Because this field is not cumulative and not affected by timing, it does not necessarily replace or duplicate the field "Regional Lymph Node Examined." Use the Surgical Codes in Appendix G to identify the regional lymph nodes for each site.

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

Use code 95 for a lymph node aspiration when the cytology or histology is positive for malignant cells.

Use code 99 if information about regional lymph nodes is unknown, or if the field is not applicable for that site or histology, i.e., unknown primaries (C80.9).

50280 - SURGERY OF OTHER REGIONAL SITES(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)-ROADS

Field Length: 1

This data field applies only to cancers diagnosed before 2003. Collection of this data item was discontinued as of 1/1/2003 with FORDS implementation.

"Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)" describes the removal of tissues(s) or organ(s) other than the primary tumor or organ of origin. This field is for all procedures that do not meet the definitions of Surgery of Primary Site or Scope of Regional Lymph Node Surgery.

Example: A patient has an excisional biopsy of a hard palate lesion is removed from the floor of the mouth and a resection of a metastatic lung nodule during the same surgical event. Code the resection of the lung nodule as 6 (distant site).

Code the removal of non-primary tissue which was removed because the surgeon suspected it was involved with malignancy even if the pathology is negative.

DO NOT CODE the incidental removal of tissue. Incidental is defined as tissue removed for reasons other than the malignancy. For example: During a colon resection, the surgeon noted that the patient had cholelithiasis and removed the gall bladder. Do not code removal of the gall bladder.

These codes are site specific and are contained in Appendix G, Surgical Codes-ROADS.

50290 - RECONSTRUCTION /RESTORATION - ROADS

Field Length: 1

This data field applies only to cancers diagnosed for 2003. Collection of this data item was discontinued as of 1/1/2003 with FORDS implementation. Only breast reconstruction continues to be recorded and this is captured in the Surgery at Primary Site-FORDS code.

"Reconstruction/Restoration" is a surgical procedure that improves the shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or cancer-directed therapies. It must be a restoration of primary site or organ.

"Reconstruction/Restoration - First Course" is limited to procedures started during the first course of therapy. Some reconstructive/restorative procedures involve several surgical events. Code as "Reconstructive/Restoration - First Course" if the first event occurred during the first course of treatment.

Each site-specific surgery code scheme in Appendix G - Surgery Codes-ROADS has either a list of reconstructive/restorative procedures or codes that define specific procedures. Code only those procedures listed under each site.

Reconstructive/restorative procedures may be performed after first course of therapy is complete. Code these procedures in this field with therapy course is "S" for subsequent therapy.

50300 - Location of Radiation Treatment

Field Length: 1

Description
Identifies the location of the facility where radiation therapy was administered during the first course of treatment It is an optional field and it is only required for data entry to ACoS flagged hospitals.

Rationale
This data item provides information useful to understanding the referral patterns for radiation therapy services and for assessing the quality and outcome of radiation therapy by delivery site.

Instructions for Coding

Code	Description
1	All radiation therapy was administered at the reporting facility. Diagnosed at autopsy.
2	Regional treatment was administered at the reporting facility; a boost dose was administered elsewhere.
3	Regional treatment was administered elsewhere; a boost dose was administered at the reporting facility.
4	All radiation therapy was administered elsewhere.
8	Radiation therapy was administered, but the pattern does not fit the above categories.
9	Radiation therapy was administered, but the location of the treatment facility is unknown or not stated in patient record; it is unknown whether radiation therapy was administered.

Examples:

Code	Reason
2	A patient received radiation therapy to the entire head and neck region at the reporting facility and is then referred to another facility for a high-dose-rate (HDR) intracavitary boost.
3	A patient was diagnosed with breast cancer at another facility and received surgery and regional radiation therapy at that facility before being referred to the reporting facility for boost dose therapy.
8	Regional treatment was initiated at another facility and midway through treatment the patient was transferred to the reporting facility to complete the treatment regime.
9	Patient is known to have received radiation therapy, but records do not define the facility or facility(s) where the treatment was administered.

50310 - Radiation Treatment Volume

Field Length: 2

Description
Identifies the volume or anatomic target of the most clinically significant regional radiation therapy delivered to the patient during the first course of treatment. It is an optional field and it is only required for data entry to ACoS flagged hospitals.

Rationale
This data item provides information describing the anatomical structures targeted by the regional radiation therapy and can be used to determine whether the site of the primary disease was treated with radiation or if other regional or distant sites were targeted. This information is useful in evaluating the patterns of care within a facility (local analysis of physician practices) and on a regional or national basis.

Instructions for Coding
Radiation treatment volume will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact treatment volume may require assistance from the radiation oncologist for consistent coding.

Code	Label	Description
01	Eye/orbit	The radiation therapy target volume is limited to the eye and/or orbit.
02	Pituitary	The target volume is restricted to the pituitary gland and all adjacent volumes are irradiated incidentally.
03	Brain (NOS)	Treatment is directed at tumors lying within the substance of the brain, or its meninges.
04	Brain (limited)	The treatment volume encompasses less than the total brain, or less than all of meninges.
05	Head and Neck (NOS)	The treatment volume is directed at a primary tumor o the oropharyngeal complex, usually encompassing regional lymph nodes.
06	Head and Neck (limited)	Limited volume treatment of a head and neck primary with the exception of glottis (code 8), sinuses (code 9), or parotid (code 10).
07	Glottis	Treatment is limited to a volume in the immediate neighborhood of the vocal cords.
08	Sinuses	The primary target is one or both of the maxillary sinuses or the ethmoidal frontal sinuses. In some

		cases, the adjacent lymph node regions may be irradiated.
09	Parotid	The primary target is one of the parotid glands. There may be secondary regional lymph node irradiation as well.
10	Chest/lung (NOS)	Radiation therapy is directed to some combination of hilar, mediastinal, and/or supraclavicular lymph nodes, and/or peripheral lung structures.
11	Lung (limited)	Radiation therapy is directed at one region of the lung without nodal irradiation.
12	Esophagus	The primary target is some portion of the esophagus. Regional lymph nodes may or may not be included in the treatment. Include tumors of the gastroesophageal junction.
13	Stomach	The primary malignancy is in the stomach. Radiation is directed to the stomach and possibly adjacent lymph nodes.
14	Liver	The primary target is all or a portion of the liver, for either primary or metastatic disease.
15	Pancreas	The primary tumor is in the pancreas. The treatment field encompasses the pancreas and possibly adjacent lymph node regions.
16	Kidney	The target is primary or metastatic disease in the kidney or the kidney bed after resection of a primary kidney tumor. Adjacent lymph node regions may be included in the field.
17	Abdomen (NOS)	Include all treatment of abdominal contents that do not fit codes 12-16.
18	Breast	The primary target is the intact breast and no attempt has been made to irradiate the regional lymph nodes.
19	Breast/lymph nodes	A deliberate attempt has been made to include regional lymph nodes in the treatment of an intact breast.
20	Chest wall	Treatment encompasses the chest wall (following mastectomy).
21	Chest wall/lymph nodes	Treatment encompasses the chest wall (following mastectomy) plus fields directed at regional lymph nodes.

22	Mantle, mini-mantle	Treatment consists of a large radiation field designed to encompass all of the regional lymph nodes above the diaphragm, including cervical, supraclavicular axillary, mediastinal, and hilar nodes (mantel), or most of them (mini-mantle). This code is used exclusively for patients with Hodgkin's or non-Hodgkin's lymphoma.
23	Lower extended field	The target zone includes lymph nodes below the diaphragm along th paraaortic chain. It may include extension to one side of the pelvis. This code includes the 'hockey stick' field utilized to treat seminomas.
24	Spine	The primary target relates to the bones of the spine, including the sacrum. Spinal cord malignancies should be coded 40 (Spinal cord).
25	Skull	Treatment is directed at the bones of the skull. Any brain irradiation is a secondary consequence.
26	Ribs	Treatment is directed toward metastatic disease in one or more ribs. Fields may be tangential or direct.
27	Hip	The target includes the proximal femur for metastatic disease. In many cases there may be acetabular disease as well.
28	Pelvic Bones	The target includes structures of the bones of the pelvis other than the hip or sacrum.
29	Pelvis (NOS)	Irradiation is directed at soft tissues within the pelvic region and codes 34-36 do not apply.
30	Skin	The primary malignancy originates in the skin and the skin is the primary target. So-called skin metastasis are usually subcutaneous and should be coded 31 (soft tissue).
31	Soft tissue	All treatment of primary or metastatic soft tissue malignancies not fitting other categories.
32	Hemibody	A single treatment volume encompassing either all structures above the diaphragm, or all structures below the diaphragm. This is almost always administered for palliation of widespread bone metastasis in patients with prostate or breast cancer.
33	Whole body	Entire body included in a single treatment.

34	Bladder and pelvis	The primary malignancy originated in the bladder, all or most of the pelvis is treated as prat of the plan, typically with a boost to the bladder.
35	Prostate and pelvis	The primary malignancy originated in the prostate, all or most of the pelvis is treated as part of the plan, typically with a boost to the prostate.
36	Uterus and cervix	Treatment is confined to the uterus and cervix or vaginal cuff, usually by intracavitary or interstitial technique. If entire pelvis is included in a portion of the treatment, then code 29 (Pelvis, NOS).
37	Shoulder	Treatment is directed to the proximal humerus, scapula, clavicle, or other components of the shoulder complex. This is usually administered for control of symptoms for metastasis.
38	Extremity bone, NOS	Bones of the arms or legs. This excludes the proximal femur, code 27 (Hip). This excludes the proximal humerus, code 37 (Shoulder).
39	Inverted Y	Treatment has been given to a field that encompasses the paraaortic and bilateral inguinal or inguinofemoral lymph nodes in a single port.
40	Spinal Cord	Treatment is directed at the spinal cord or its meninges.
41	Prostate	Treatment is directed at the prostate with or without the seminal vesicles, without regional lymph node treatment.
50	Thyroid	Treatment is directed at the thyroid gland.
60	Lymph node region, NOS	The target is a group of lymph nodes not listed above. Examples include isolated treatment of a cervical, supraclavicular, or inguinofemoral region.
98	Other	Radiation therapy administered, treatment volume other than those previously categorized.
99	Unknown	Radiation therapy administered, treatment volume unknown or not stated in patient record; it is unknown if radiation therapy was administered.

Examples:

Code	Reason
01	Lymphoma of the orbit treated with 4 cm x 4 cm portals.

02 Pituitary adenomas receiving small opposed field or rotational treatment.
03 The entire brain is treated for metastatic disease.

50320 - Regional Treatment Modality

Field Length: 2

Description
Records 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. It is an optional field and it is only required for data entry to ACoS flagged hospitals.

Rationale
Radiation treatment is frequently delivered in two or more phases which can be summarized as "regional" and "boost" treatments. To evaluate patterns of radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very important.

Instructions for Coding
- Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into regional and boost and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.
- In the event multiple radiation therapy modalities were employed in the treatment of the patient, record only the dominant modality.
- Note that in some circumstances the boost treatment may precede the regional treatment.
- For purposes of this data item, photons and x-rays are equivalent.

Code	Label	Description
20	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific modality.
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt-60 or Cesium-137 source. Intracavitary use of these sources is coded either 50 or 51.
23	Photons (2-5 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 2-5 MV.
24	Photons (6-10 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 6-10 MV.

25	Photons (11-19 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 11-19 MV.
26	Photons (>19 MV)	External beam therapy using a photon producing machine with a beam energy of more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons, with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials not otherwise specified. Includes radioembolization.
51	Brachytherapy, Intracavity, LDR	Intracavitary (no direct insertion into tissues) radio-isotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, Intracavity, HDR	Intracavitary (no direct insertion into tissues) radio-isotope treatment using high dose rate after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources.
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources.

55	Radium	Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy.
60	Radioisotopes, NOD	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	
98	Other, NOS	Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

50330 - Regional Dose: cGy

Field Length: 5

Description
Records the dominant or most clinically significant total dose of regional radiation therapy delivered to the patient during the first course of treatment. The unit of measure is centigray (cGy). It is an optional field and it is only required for data entry to ACoS flagged hospitals.

Rationale
To evaluate patterns of radiation oncology care, it is necessary to capture information describing the prescribed regional radiation dose. Outcomes are strongly related to the dose delivered.

Instructions for Coding

- The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the dose as indicated in the summary chart. Determining the exact dose may be highly subjective and require assistance from the radiation oncologist for consistent coding.
- Regional dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the total dose of regional therapy may require assistance from the radiation oncologist for consistent coding.
- For photon treatment, dosage is reported in cGe units (Cobalt Grey Equivalent) rather than cGy. *You must multiply cGe by 100 to get cGy.*
    - Do not include the boost dose, if one was administered.
    - Code 88888 when brachytherapy or radioisotopes - codes 50-62 for Regional Treatment Modality - were administered to the patient.
    - Note that dose is still occasionally specified in "rads." One rad is equivalent to one centigray (cGy).

Code	Description
(fill spaces)	Record the actual regional dose delivered.
88888	Not applicable, brachytherapy or radioisotopes administered to the patient.
99999	Regional radiation therapy was administered, but the dose is unknown; it is unknown whether radiation therapy was administered.

50340 - Boost Treatment Modality

Field Length: 2

Description
Records the dominant modality of radiation therapy used to deliver he 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. It is an optional field and it is only required for data entry to ACoS flagged hospitals.

Rationale
Radiation treatment is frequently delivered in two or more phases which can be summarized as "regional" and "boost" treatments. To evaluate patterns of radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very important.

Instructions for Coding
- Radiation boost treatment modalities will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into regional and boost and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.
- In the event that multiple radiation therapy boost modalities were employed during the treatment of the patient, record only the dominant modality.
- Note that in some circumstances, the boost treatment may precede the regional treatment.
- For purposes of this field, photons and x-rays are equivalent.

Code	Label	Description
00	No boost treatment	A boost dose was no administered to the patient.
20	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific modality.
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt-60 or Cesium-137 source. Intracavitary use of these sources is coded either 50 or 51.

23	Photons (2-5 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 2-5 MV.
24	Photons (6-10 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 6-10 MV.
25	Photons (11-19 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 11-19 MV.
26	Photons (>19 MV)	External beam therapy using a photon producing machine with a beam energy of more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons, with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials not otherwise specified. Includes radioembolization.
51	Brachytherapy, Intracavity, LDR	Intracavitary (no direct insertion into tissues) radio-isotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator).

52	Brachytherapy, Intracavity, HDR	Intracavitary (no direct insertion into tissues) radio-isotope treatment using high dose rate after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources.
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources.
55	Radium	Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy.
60	Radioisotopes, NOD	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	
98	Other, NOS	Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether boost treatment was administered.

50350 - Boost Dose: cGy

Field Length: 5

Description
Records the additional dose delivered to that part of the treatment volume encompassed by the boost fields or devices. The unit of measure is centiGray (cGy). It is an optional field and it is only required for data entry to ACoS flagged hospitals.

Rationale
To evaluate patterns of radiation oncology care, it is necessary to capture information describing the prescribed boost radiation dose. Outcomes are strongly related to the dose delivered.

Instructions for Coding
- The International Council for Radiation (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the dose as indicated in the summary chart. Consult the radiation oncologist for the exact dose, if necessary.
- Radiation boost treatment will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the additional boost dose of radiation therapy may require assistance from the radiation oncologist for consistent coding.
- Do not include the regional dose. In general, the boost dose will be calculated as the difference between the maximum prescribed dose and the regional dose. Many patients will not have a boost.
- Code 88888 when brachytherapy or radioisotopes - codes 50-62 for Boost Treatment Modality - were administered to the patient.
- Note that dose is still occasionally specified in "rads" One rad is equivalent to one centiGray (cGy).

Code	Description
(fill spaces)	Record the actual regional dose delivered.
88888	Not applicable, brachytherapy or radioisotopes administered to the patient.
99999	Regional radiation therapy was administered, but the dose is unknown; it is unknown whether radiation therapy was administered.

50360 - Number of Treatments To This Volume

Field Length: 3

Description
Records the total number of treatment sessions (fractions) administered during the first course of treatment. It is an optional field and it is only required for data entry to ACoS flagged hospitals.

Rationale
This data item is used to evaluate patterns of radiation therapy and the treatment schedules.

Instructions for Coding

- The number of treatments or fractions will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact number of treatments or fractions delivered to the patient may require assistance from the radiation oncologist for consistent coding.
- Although a treatment session may include several treatment portals delivered within relatively confined period of time - usually a few minutes - it is still considered one session.
- The total number of treatment sessions (fractions) is the sum of the number of fractions of regional treatment and the number of fractions of boost treatment.

Code	Label	Description
000	None	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
001-998	Number of Treatments	Total number of treatment sessions administered to the patient.
999	Unknown	Radiation therapy was administered, but the number of treatments is unknown. Or, it is unknown whether radiation therapy was administered. Death certificate only.

Examples:

Code	Reason
025	A patient with breast carcinoma had treatment sessions in which treatment was delivered to the chest wall and separately to the ipsilateral supraclavicular region for a total of three treatment portals. Twenty-five treatment sessions were given. Record 25 treatments.
035	A patient with Stage IIIB bronchogenic carcinoma received 25 treatments to the left hilum and mediastinum, given in 25 daily treatments over five weeks. A left hilar boost was then given in 10 additional treatments. Record 35 treatments.
050	A patient with advanced head and neck cancer was treated using "hyperfractionation." Three fields were delivered in each session, two sessions were given each day, six hours

apart, with each session delivering a total dose of 150 cGy. Treatment was given for a total of 25 days. Record 50 treatments.

50370 - Date Radiation Ended

Field Length: 8

Description
The date on which the patient completes or received the last radiation treatment at any facility. It is an optional field and it is only required for data entry to ACoS flagged hospitals.

Rationale
The length of time over which radiation therapy is administered to a patient is a factor in tumor control and treatment morbidity. It is useful to evaluate the quality of care and the success of patient support programs designed to maintain continuity of treatment.

Instructions for Coding
The date when treatment ended will typically be found in the radiation oncologist's summary letter for the first course of treatment.

Code	Description
MMDDCCYY	The month, day, and year (MMDDCCYY) radiation therapy ended at any facility. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
88888888	When radiation was administered and was still ongoing at the time of most recent follow-up. The date should be revised at the next follow-up.
99999999	When it is unknown whether any radiation therapy was administered, the date is unknown, or the case was identified by death certificate only.

50371 - Date Radiation Ended Flag

Field Length: 2

This is a calculated field which explains why there is no appropriate value in the field Date Radiation Ended (item #50370).

Codes

Code	Description
10	No information whatsoever can be inferred (for example, unknown if radiation was given)
11	No proper value is applicable in this context (that is, no radiation given)
12	A proper value is applicable but not known (that is, radiation was given, but the date is unknown)
15	Information is not available at this time, but it is expected that it will be available later (that is, radiation therapy had begun at the time of the most recent follow-up, but was not yet completed)
(blank)	A valid date value is provided

50380 - Treatment Notes/Agents

Field Length: 1000

This field is available with each of the therapy types: surgery, radiation, chemotherapy, etc. It is an optional text field in which you may wish to record notes about a specific therapeutic occurrence or regimen. For chemotherapy, hormone and immunotherapy, enter the names or abbreviations (separated by a comma) of the treatment agents used. A list of names and accepted abbreviations is available in SEER Rx and Appendix H. A list of common abbreviations for combination regimens of therapy is also included in SEER Rx and Appendix H.

Use this field to code 'PALL' for palliative surgery, radiation, or chemotherapy.

50385 - Therapy Clinical Trial Number

Choose the Clinical Trial number coded in the patient segment of the abstract where this treatment is part of the protocol or treatment regimen.

Code	Description
0	None or unknow
1	Clinical Trial 1
2	Clinical Trial 2
3	Clinical Trial 3
4	Clinical Trial 4

50390 - LAST MODIFICATION BY

Field Length: 8

The user name of the last individual to modify therapy data is automatically recorded in this field and is updated each time the record is edited.

50400 - LAST MODIFICATION TIME

Field Length: 19

The date and time that therapy data was last modified is automatically recorded in this field and is updated each time the record is edited.

NAACCR Tx

60025 - Rx Hosp--Surg Approach 2010

Field Length: 1

This is a calculated field which describes the surgical method used to approach the primary site for the most invasive surgery of the primary site at this facility. This field is blank for cases diagnosed prior to January 1, 2010.

Code	Description
0	No surgical procedure of primary site at this facility; Diagnosed at autopsy
1	Robotic assisted
2	Robotic converted to open
3	Endoscopic
4	Endoscopic converted to open
5	Open or approach unspecified
9	Unknown whether surgery was performed at this facility

60030 - Rx Hosp--Surg Prim Site

Field Length: 2

This is a calculated field which records the most invasive surgical procedure at the primary site which was performed at the reporting facility.

Code	Description
00	No surgical procedure of primary site. Autopsy only.
10-19	Site-specific codes. Tumor destruction; no pathologic specimen produced.
20-80	Site-specific codes. Resection. Path specimen produced.
90	Surgery, NOS.
98	Site-specific codes. Special
99	Unknown. Death certificate only.

60040 - Rx Hosp--Scope Reg LN Sur

Field Length: 1

Calculated field which records the removal, biopsy, or aspiration of regional lymph node(s) at the reporting facility. If multiple lymph node procedures were performed, the highest code predominates.

Codes

Code	Description
0	No regional lymph nodes removed
1	Biopsy or aspiration of regional lymph node, NOS
2	Sentinel lymph node biopsy
3	Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS
4	1 to 3 regional lymph nodes removed
5	4 or more regional lymph nodes removed
6	Sentinel node biopsy and code 3, 4, or 5 at the same time or time not stated
7	Sentinel node biopsy and code 3, 4, or 5 at different times
9	Unknown or not applicable

60050 - Rx Hosp--Surg Oth Reg/Dis

Field Length: 1

This calculated field records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) at the reporting facility. If multiple procedures to other sites were performed, the highest code (excluding 9) is recorded.

Code	Description
0	None. Diagnosed at autopsy.
1	Non-primary surgical resection to other site(s), unknown if regional or distant.
2	Resection of regional site.
3	Resection of distant lymph node(s).
4	Resection of distant site.
5	Any combination of codes 2, 3, or 4
9	Unknown or death certificate only.

60060 - Rx Hosp--Reg LN Removed

Field Length: 2

This field only applies to cases diagnosed prior to January 1, 2003. It is a calculated field which describes the number of regional lymph nodes removed as part of first course treatment at the reporting facility.

Codes

Code	Description
00	No regional lymph nodes removed
01-89	One to 89 regional lymph nodes removed
90	Ninety or more regional lymph nodes removed
95	No regional lymph node(s) removed, but aspiration of regional lymph node(s) was performed
96	Regional lymph node removal documented as sampling and number of lymph nodes unknown/not stated
97	Regional lymph node removal documented as a dissection and number of lymph nodes unknown/not stated
98	Regional lymph nodes surgically removed, but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99	Unknown; not stated; death certificate only

60070 - Rx Hosp--Radiation

Field Length: 1

This field only applies to cases diagnosed prior to January 1, 2003. It is a calculated field which specifies the type of radiation therapy the patient received as part of the initial treatment at the reporting facility.

Code	Description
0	None
1	Beam Radiation
2	Radioactive implants
3	Radioisotopes
4	Combination of 1 with 2 or 3
5	Radiation, NOS
9	Unknown if radiation therapy administered

60080 - Rx Hosp--Chemo

Field Length: 2

This is a calculated field which specifies the type of chemotherapy the patient received as part of their initial treatment at the reporting facility. If chemotherapy was not administered, this item records the reason.

Code	Description
00	None, chemotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Chemotherapy administered as part of first course therapy, but the type and number of agents is not documented.
02	Single-agent chemotherapy administered as first course therapy.
03	Multi-agent chemotherapy administered as first course therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors.
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in the 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 the patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether chemotherapy was recommended or administered because it is not stated in the patient record. Death certificate only.

60090 - Rx Hosp--Hormone

Field Length: 2

This is a calculated field which records whether systemic hormonal agents were administered as first course treatment at the reporting facility, or records the reason they were not given.

Codes

Code	Description
00	None, hormone therapy was not administered as part of first course treatment. Diagnosed at autopsy.
01	Hormone therapy was given as first course therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors.
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 first course therapy. No reason was stated in the patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but 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 hormone therapy was recommended or administered because it is not stated in the patient record. Death certificate only.

60100 - Rx Hosp--BRM

Field Length: 2

This is a calculated field which records whether immunotherapeutic agents (biologic response modifiers) were administered as first course treatment at the reporting facility, or records the reason they were not given.

Codes

Code	Description
00	None, immunotherapy was not administered as part of first course treatment. Diagnosed at autopsy.
01	Immunotherapy was given as first course therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors.
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 first course therapy. No reason was stated in the patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but 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 immunotherapy was recommended or administered because it is not stated in the patient record. Death certificate only.

60110 - Rx Hosp--Other

Field Length: 1

This is a calculated field which identifies other treatment given at the reporting facility that cannot be defined as surgery, radiation, or systemic therapy, or records the reason it was not given.

Code	Description
0	None. All cancer treatment was coded in other treatment fields. Diagnosed at autopsy.
1	Cancer treatment that cannot be assigned to other fields was given. Use this code for treatment unique to hematopoietic diseases.
2	Patient received treatment as part of an institution based clinical trial.
3	Patient received treatment as part of a double-blind clinical trial. Code the treatment actually administered when the double-blind code is broken.
6	Cancer treatments administered by nonmedical personnel.
7	Other treatment was not administered. It was recommended by the patient's physician, but was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
8	Other treatment was recommended, but it is unknown whether it was administered.
9	It is unknown whether other treatment was recommended or administered because it is not stated in the patient record. Death certificate only.

60120 - Rx Hosp--Dx/Stg Proc

Field Length: 2

This is a calculated field which identifies surgical procedure(s) performed at the reporting facility in order to diagnose and/or stage disease.

Codes

Code	Description
00	No surgical diagnostic or staging procedure was performed.
01	A biopsy (incisional, needle, or aspiration) was done to a site other than the primary site. No exploratory procedure was done.
02	A biopsy (incisional, needle, or aspiration) was done to the primary site; or biopsy or removal of a lymph node to diagnose or stage lymphoma.
03	A surgical exploration only. The patient was not biopsied or treated.
04	A surgical procedure with a bypass was performed, but no biopsy was done.
05	An exploratory procedure was performed, and a biopsy of either the primary site or another site was done.
06	A bypass procedure was performed, and a biopsy of either the primary site or another site was done.
07	A procedure was done, but the type of procedure is unknown.
09	No information regarding whether a diagnostic or staging procedure was performed.

60130 - Rx Hosp--Palliative Proc

Field Length: 1

This is a calculated field which identifies care provided at the reporting facility in an effort to palliate or alleviate symptoms. Palliative procedures are performed to relieve symptoms and may included surgery, radiation therapy, systemic therapy, and/or pain management therapy.

Code	Description
0	No palliative care provided. Diagnosed at autopsy.
1	Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
2	Radiation therapy to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
3	Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
4	Patient received or was referred for pain management therapy with no other palliative care.
5	Any combination of codes 1, 2, and/or 3 without code 4.
6	Any combination of codes 1, 2, and/or 3 with code 4.
7	Palliative care was performed or referred, but no information on the type of procedure is available in patient record. Palliative care was provided that does not fit the descriptions in codes 1-6.
9	It is unknown if palliative care was performed or referred; not stated in patient record.

60140 - Rx Hosp--Surg Site 98-02

Field Length: 2

This field only applies to cases diagnosed prior to January 1, 2003. It is a calculated field which describes the most invasive surgical procedure to the primary site performed at the reporting facility. Site specific surgery codes are taken from the ROADS Manual.

Special codes

Code	Description
00	No cancer directed surgery performed
99	Unknown if cancer directed surgery performed

60150 - Rx Hosp--Scope Reg 98-02

Field Length: 1

This field only applies to cases diagnosed prior to January 1, 2003. It is a calculated field which describes the removal, biospy, or aspiration of regional lymph nodes(s) at the reporting facility. Site specific surgery codes are taken from the ROADS Manual.

60160 - Rx Hosp--Surg Oth 98-02

Field Length: 1

This field only applies to cases diagnosed prior to January 1, 2003. It is a calculated field which records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site at the reporting facility. Site specific surgery codes are taken from the ROADS Manual.

60170 - Rx Date--Surgery

Field Length: 8

This is a calculated field which records the date the first surgery described in Surgery of Primary Site, Scope of Regional Lymph Node Surgery, or Surgery of Other Regional/Distant Sites was performed.

Special Codes

Code	Description
00000000	No surgical procedures performed; autopsy only
99999999	Unknown if any surgical procedures were performed, date of surgical procedure is unknown, or death certificate only

60171 - Date Surgery Flag

Field Length: 2

This is a calculated field which explains why there is no appropriate value in the field Rx Date--Surgery (item #60170).

Code	Description
10	No information whatsoever can be inferred (i.e., unknown if any surgery was performed)
11	No proper value is applicable in this context (i.e., no surgery performed)
12	A proper value is applicable but not known (i.e., surgery was performed, but the date is unknown)
(blank)	A valid date value is provided

60180 - Rx Date--Most Defin Surg

Field Length: 8

This is a calculated field which records the date of the most definitive surgical resection of the primary site as part of the first course of treatment.

Special codes

Code	Description
00000000	No surgical resection of the primary site. Diagnosed at autopsy.
99999999	Unknown if any surgical procedure of primary site was performed, or date of surgery at primary site is unknown. Death certificate only.

60181 - Date Most Defin Surg Flag

Field Length: 2

This is a calculated field which explains why there is no appropriate value in the field Rx Date--Most Defin Surg (item #60180). This field is blank for cases diagnosed prior to January 1, 2003.

Code	Description
10	No information whatsoever can be inferred (i.e., unknown if any surgery was performed)
11	No proper value is applicable in this context (i.e., no surgery performed)
12	A proper value is applicable but not known (i.e., surgery was performed, but the date is unknown)
(blank)	A valid date value is provided

60190 - Rx Date--Surgical Disch

Field Length: 8

This is a calculated field which records the date the patient was discharged following the most definitive primary site surgery.

Special codes

Code	Description
00000000	No surgical procedures performed; autopsy only
99999999	Unknown if any surgical procedures were performed, date of surgical procedure is unknown, or death certificate only

60191 - Date Surgical Disch Flag

Field Length: 2

This is a calculated field which explains why there is no appropriate value in the field Rx Date--Surgical Disch (item #60190). This field is blank for cases diagnosed prior to January 1, 2003.

Code	Description
10	No information whatsoever can be inferred (i.e., unknown if any surgery was performed)
11	No proper value is applicable in this context (i.e., no surgery performed)
12	A proper value is applicable but not known (i.e., surgery was performed, but the date is unknown)
(blank)	A valid date value is provided

60200 - Rx Date--Radiation

Field Length: 8

This is a calculated field which records the date on which radiation therapy began at any facility as part of the first course of treatment.

Special Codes

Code	Description
00000000	No radiation therapy administered; autopsy only cases.
88888888	Radiation therapy was planned as part of the first course of therapy, but has not yet been administered.
99999999	Unknown if radiation therapy was administered; date of radiation unknown; death certificate only cases.

60201 - Date Radiation Flag

Field Length: 2

This is a calculated field which explains why there is no appropriate value in the field Rx Date--Radiation (item #60200).

Code	Description
10	No information whatsoever can be inferred (i.e., unknown if any radiation was given)
11	No proper value is applicable in this context (i.e., no radiation given)
12	A proper value is applicable but not known (i.e., radiation was given, but the date is unknown)
15	Information not available at this time, but it is expected that it will be available later (i.e., radiation is planned as part of first course therapy, but has not been started at the time of the most recent follow-up)
(blank)	A valid date value is provided

60210 - Rx Date--Radiation Ended

Field Length: 8

This is a calculated field which records the date on which the patient completes or receives the last radiation treatment at any facility.

Special Codes

Code	Description
00000000	No radiation therapy administered; autopsy only cases.
88888888	Radiation therapy was planned as part of the first course of therapy, but has not yet been administered.
99999999	Unknown if radiation therapy was administered; date of radiation unknown; death certificate only cases.

60211 - Date Radiation Ended Flag

Field Length: 2

This is a calculated field which explains why there is no appropriate value in the field Rx Date--Radiation Ended (item #60210).

Code	Description
10	No information whatsoever can be inferred (i.e., unknown if any radiation was given)
11	No proper value is applicable in this context (i.e., no radiation given)
12	A proper value is applicable but not known (i.e., radiation was given, but the date is unknown)
15	Information not available at this time, but it is expected that it will be available later (i.e., radiation had begun at the time of the most recent follow-up, but was not yet completed)
(blank)	A valid date value is provided

60220 - Rx Date--Systemic

Field Length: 8

This is a calculated field which records the date of initiation of systemic therapy as part of the first course of treatment. Systemic therapy includes the administration of chemotherapy agents, hormone agents, biologic response modifiers, bone marrow transplants, stem cell harvests, and surgical and/or radiation endocrine therapy.

Special Codes

Code	Description
00000000	No systemic therapy administered; autopsy only cases.
88888888	Systemic therapy was planned as part of the first course of therapy, but has not yet been administered.
99999999	Unknown if systemic therapy was administered; date of systemic therapy unknown; death certificate only cases.

60221 - Date Systemic Flag

Field Length: 2

This is a calculated field which explains why there is no appropriate value in the field Rx Date--Systemic (item #60220).

Code	Description
10	No information whatsoever can be inferred (i.e., unknown if any systemic therapy was given)
11	No proper value is applicable in this context (i.e., no systemic therapy given)
12	A proper value is applicable but not known (i.e., systemic therapy was given, but the date is unknown)
15	Information not available at this time, but it is expected that it will be available later (i.e., systemic therapy is planned as part of first course therapy, but has not been started at the time of the most recent follow-up)
(blank)	A valid date value is provided

60230 - RX DATE--CHEMO

Field Length: 8

This is a calculated field which records the date of initiation of chemotherapy at any facility as part of the first course of treatment.

Special Codes

Code	Description
00000000	No chemotherapy administered; autopsy only cases.
88888888	Chemotherapy was planned as part of the first course of therapy, but has not yet been administered.
99999999	Unknown if chemotherapy was administered; date of chemotherapy unknown; death certificate only cases.

60231 - Date Chemo Flag

This is a calculated field which explains why there is no appropriate value in the field Rx Date--Chemo (item #60230).

Code	Description
10	No information whatsoever can be inferred (i.e., unknown if any chemotherapy was given)
11	No proper value is applicable in this context (i.e., no chemotherapy given)
12	A proper value is applicable but not known (i.e., chemotherapy was given, but the date is unknown)
15	Information not available at this time, but it is expected that it will be available later (i.e., chemotherapy is planned as part of first course therapy, but has not been started at the time of the most recent follow-up)
(blank)	A valid date value is provided

60240 - RX DATE--HORMONE

Field Length: 8

This is a calculated field which records the date of initiation of hormone therapy at any facility as part of the first course of treatment.

Special Codes

Code	Description
00000000	No hormone therapy administered; autopsy only cases.
88888888	Hormone therapy was planned as part of the first course of therapy, but has not yet been administered.
99999999	Unknown if hormone therapy was administered; date of hormone therapy unknown; death certificate only cases.

60241 - DATE HORMONE FLAG

Field Length: 2

This is a calculated field which explains why there is no appropriate value in the field Rx Date--Hormone (item #60240).

Code	Description
10	No information whatsoever can be inferred (i.e., unknown if any hormone therapy was given)
11	No proper value is applicable in this context (i.e., no hormone therapy given)
12	A proper value is applicable but not known (i.e., hormone therapy was given, but the date is unknown)
15	Information not available at this time, but it is expected that it will be available later (i.e., hormone therapy is planned as part of first course therapy, but has not been started at the time of the most recent follow-up)
(blank)	A valid date value is provided

60250 - RX DATE--BRM

Field Length: 8

This is a calculated field which records the date of initiation of immunotherapy at any facility as part of the first course of treatment.

Special Codes

Code	Description
00000000	No immunotherapy administered; autopsy only cases.
88888888	Immunotherapy was planned as part of the first course of therapy, but has not yet been administered.
99999999	Unknown if immunotherapy was administered; date of immunotherapy unknown; death certificate only cases.

60251 - DATE BRM FLAG

Field Length: 2

This is a calculated field which explains why there is no appropriate value in the field Rx Date--BRM (item #60250).

Code	Description
10	No information whatsoever can be inferred (i.e., unknown if any immunotherapy was given)
11	No proper value is applicable in this context (i.e., no immunotherapy given)
12	A proper value is applicable but not known (i.e., immunotherapy was given, but the date is unknown)
15	Information not available at this time, but it is expected that it will be available later (i.e., immunotherapy is planned as part of first course therapy, but has not been started at the time of the most recent follow-up)
(blank)	A valid date value is provided

60260 - RX DATE -- OTHER

Field Length: 8

This is a calculated field which records the date of initiation of other treatment at any facility as part of the first course of treatment.

Special Codes

Code	Description
00000000	No other treatment administered; autopsy only cases.
88888888	Other treatment was planned as part of the first course of therapy, but has not yet been administered.
99999999	Unknown if other treatment was administered; date of other treatment unknown; death certificate only cases.

60261 - DATE OTHER FLAG

Field Length: 2

This is a calculated field which explains why there is no appropriate value in the field Rx Date--Other (item #60260).

Code	Description
10	No information whatsoever can be inferred (i.e., unknown if any other therapy was given)
11	No proper value is applicable in this context (i.e., no other therapy given)
12	A proper value is applicable but not known (i.e., other therapy was given, but the date is unknown)
15	Information not available at this time, but it is expected that it will be available later (i.e., other therapy is planned as part of first course therapy, but had not been started at the time of the most recent follow-up)
(blank)	A valid date value is provided

60270 - Rx Date--Date of Initial Rx SEER

Field Length: 8

This is a calculated field which records the initiation of the first course of therapy. This is the start date of any type of treatment for cancer. Treatment may be given in a hospital or non-hospital setting. The third and fourth digits (day) are re-coded to 99 when the data are transmitted to SEER.

Special Codes

Code	Description
00000000	No cancer-directed therapy
99999999	Unknown if therapy administered, or unknown date of therapy

60271 - Date of Initial Rx SEER Flag

Field Length: 2

This is a calculated field which explains why there is no appropriate value in the field Rx Date--Date of Initial Rx SEER (item #60270).

Code	Description
10	No information whatsoever can be inferred (e.g.., unknown if therapy was administered)
11	No proper value is applicable in this context (e.g., therapy was not administered)
12	A proper value is applicable but not known (e.g., therapy was given, but the date is unknown)
(blank)	A valid date is provided

60280 - RX DATE--DATE OF 1st CRS RX COC

Field Length: 8

This is a calculated field which records the date on which treatment began at any facility, using the CoC definition of first course. The date of first treatment includes the date a decision was made not to treat the patient.

Special Codes

Code	Description
00000000	Diagnosed at autopsy
99999999	Unknown if any treatment was administered, treatment date unknown, or death certificate only

60281 - Date of 1st Crs Rx COC Flag

Field Length: 2

This is a calculated field which explains why there is no appropriate value in the field Rx Date--Date of 1st Course Rx COC (item # 60280).

Code	Description
10	No information whatsoever can be inferred (e.g.., unknown if therapy was administered)
11	No proper value is applicable in this context (e.g., therapy was not administered)
12	A proper value is applicable but not known (e.g., therapy was given, but the date is unknown)
(blank)	A valid date is provided

60290 - RX DATE--DX/STG PROC

Field Length: 8

This is a calculated field which records the date on which the first surgical diagnostic and/or staging procedure was performed at any facility.

Special codes

Code	Description
00000000	No diagnostic or staging procedure performed; autopsy only cases
99999999	Unknown if diagnostic or staging procedure performed, or date of procedure unknown; death certificate only

60291 - Date Dx/Stg Proc Flag

Field Length: 2

This is a calculated field which explains why there is no appropriate value in the field Rx Date--Dx/Stg Proc (item #60290). This field is blank for cases diagnosed prior to January 1, 2007.

Code	Description
10	No information whatsoever can be inferred (i.e., unknown if any diagnostic or staging procedure performed)
11	No proper value is applicable in this context (i.e., no no diagnostic or staging procedure performed)
12	A proper value is applicable but not known (i.e., diagnostic or staging procedure was performed, but the date is unknown)
(blank)	A valid date value is provided

60295 - RX SUMM --TREATMENT STATUS

Field Length: 1

This is a calculated field which summarizes whether the patient received any treatment or if the tumor was under active surveillance. It is blank for case diagnosed prior to 2010.

Treatment given after a period of active surveillance is considered subsequent treatment and is not coded in this item.

Code	Definition
0	No treatment given
1	Treatment given
2	Active surveillance (watchful waiting)
9	Unknown if treatment was given

60300 - RX SUMM--SURG PRIM SITE

Field Length: 2

This is a calculated field which records the code for the most definitive site specific surgery performed as first course of treatment at any facility.

Code	Description
00	No surgical procedure of primary site. Diagnosed at autopsy.
10-19	Tumor destruction, no pathologic specimen produced.
20-80	Tumor resection.
90	Surgery, NOS
98	Special code.
99	Unknown if surgery at primary site. Death certificate only.

60310 - RX SUMM--SCOPE REG LN SUR

Field Length: 1

This is a calculated field which describes the removal, biopsy, or aspiration of regional lymph nodes(s) at any facility. These codes are hierarchical and the numerically highest code (excluding 9) is recorded.

Code	Description
0	No regional lymph nodes removed
1	Biopsy or aspiration of regional lymph node, NOS
2	Sentinel lymph node biopsy
3	Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS
4	1 to 3 regional lymph nodes removed
5	4 or more regional lymph nodes removed
6	Sentinel node biopsy and code 3, 4, or 5 at the same time or time not stated
7	Sentinel node biopsy and code 3, 4, or 5 at different times
9	Unknown or not applicable

60320 - RX SUMM--SURG OTH REG/DIS

Field Length: 1

This is a calculated field which records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site performed at any facility. These codes are hierarchical; if multiple procedures to distant lymph nodes or sites were performed, the highest code (excluding 9) predominates.

Code	Description
0	None. Diagnosed at autopsy.
1	Non-primary surgical resection to other site(s), unknown if regional or distant.
2	Resection of regional site.
3	Resection of distant lymph node(s).
4	Resection of distant site.
5	Any combination of codes 2, 3, or 4
9	Unknown or death certificate only.

60330 - RX SUMM--REG LN EXAMINED

Field Length: 2

This field applies to cases diagnosed prior to January 1, 2003. This is a calculated code which indicates the number of lymph nodes surgically examined.

Code	Description
00	No regional lymph nodes removed
01-89	One to 89 regional lymph nodes removed
90	Ninety or more regional lymph nodes removed
95	No regional lymph node(s) removed, but aspiration of regional lymph node(s) was performed
96	Regional lymph node removal documented as sampling and number of lymph nodes unknown/not stated
97	Regional lymph node removal documented as a dissection and number of lymph nodes unknown/not stated
98	Regional lymph nodes surgically removed, but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99	Unknown; not stated; death certificate only

60340 - RX SUMM--SURGICAL APPROACH

Field Length: 1

This field only applies to cases diagnosed prior to January 1, 2003. This is a calculated field which records the method used to approach the surgical field for the primary site. These codes are site-specific and may be found in the ROADS Manual.

60350 - RX SUMM--SURGICAL MARGINS

Field Length: 1

This field only applies to cases diagnosed prior to January 1, 2003. This is a calculated field which records the final status of the surgical margins after resection of the primary tumor.

Code	Descriptions
0	All margins are grossly and microscopically negative.
1	Involvement is indicated, but not otherwise specified.
2	Microscopic residual tumor.
3	Macroscopic residual tumor.
7	Cannot be assessed.
8	No surgical procedure of the primary site; diagnosed at autopsy.
9	Unknown or not applicable.

60360 - RX SUMM--RECONSTRUCT 1ST

Field Length: 1

This field only applies to cases diagnosed prior to January 1, 2003. It is a calculated field which records surgical procedures done to reconstruct, restore, or improve the shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or cancer-directed therapies. These codes are site-specific and may be found in the ROADS Manual.

60370 - REASON NO SURG

Field Length: 1

This is a calculated field which records the reason that no surgery was performed on the primary site.

Code	Description
0	Surgery of the primary site was performed.
1	Surgery of the primary site was not performed because it was not part of the planned first course treatment
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
6	Surgery was recommended by the patient's physician, but was not performed. No reason was noted in the patient's record.
7	Surgery was recommended by the patient's physician, but was refused by the patient, patient's family member, or guardian. Refusal was noted in the patient record.
8	Surgery was recommended, but it is unknown if it was performed.
9	It is unknown if surgery was recommended or performed. Death certificate only cases.

60380 - RX SUMM--DX/STG PROC

Field length: 2

This is a calculated field which identifies the surgical procedure(s) performed at any facility in an effort to diagnose and/or stage disease.

Code	Description
00	No surgical diagnostic or staging procedure was performed.
01	A biopsy (incisional, needle, or aspiration) was done to a site other than the primary site. No exploratory procedure was done.
02	A biopsy (incisional, needle, or aspiration) was done to the primary site; or biopsy or removal of a lymph node to diagnose or stage lymphoma.
03	A surgical exploration only. The patient was not biopsied or treated.
04	A surgical procedure with a bypass was performed, but no biopsy was done.
05	An exploratory procedure was performed, and a biopsy of either the primary site or another site was done.
06	A bypass procedure was performed, and a biopsy of either the primary site or another site was done.
07	A procedure was done, but the type of procedure is unknown.
09	No information regarding whether a diagnostic or staging procedure was performed.

60390 - RX SUMM--PALLIATIVE PROC

Field Length: 1

This is a calculated field which identifies care provided at any facility in an effort to palliate or alleviate symptoms.

Code	Description
0	No palliative care provided. Diagnosed at autopsy.
1	Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
2	Radiation therapy to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
3	Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
4	Patient received or was referred for pain management therapy with no other palliative care.
5	Any combination of codes 1, 2, and/or 3 without code 4.
6	Any combination of codes 1, 2, and/or 3 with code 4.
7	Palliative care was performed or referred, but no information on the type of procedure is available in patient record. Palliative care was provided that does not fit the descriptions in codes 1-6.
9	It is unknown if palliative care was performed or referred; not stated in patient record.

60400 - Rx Summ--Radiation

Field Length: 1

This is a calculated field which records the type of radiation therapy given at any facility as part of the first course of treatment.

Code	Description
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
6	Historic cases (pre-1996)
7	Patient or patient's guardian refused
8	Radiation recommended, unknown if administered
9	Unknown if radiation therapy administered

60410 - RX SUMM--RAD TO CNS

Field Length: 1

This field only applies to lung and leukemia cases diagnosed prior to 1996. It is a calculated field which records radiation given to the brain or central nervous system.

Code	Description
0	No radiation to the brain and/or CNS
1	Radiation
7	Patient or patient's guardian refused
8	Radiation recommended, unknown if administered
9	Unknown or not applicable

60420 - Rx Summ--Surg/Rad Seq

Field Length: 1

This is a calculated field which records the sequencing of radiation and surgery performed as part of first course of treatment. Surgery may be to the primary site, regional lymph nodes, or other site(s).

Code	Description
0	No radiation and/or no cancer-directed surgery
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	Both surgery and radiation given, but sequence unknown

60430 - Rx Summ--Transplnt/Endocr

Field Length: 2

This is a calculated field which identifies transplant and endocrine surgeries/radiation administered at any facility as part of the first course of treatment.

Code	Description
00	None; diagnosed at autopsy
10	Bone marrow transplant, type 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 (code 30 plus 10, 11, 12, or 20)
82	Transplant and/or endocrine surgery/radiation not recommended/administered because it was contraindicated due to patient risk factors
85	Transplant and/or endocrine surgery/radiation not administered because the patient died prior to planned or recommended therapy
86	Transplant and/or endocrine surgery/radiation recommended by the patient's physician, but was not administered; no reason was stated in the patient record
87	Transplant and/or endocrine surgery/radiation recommended by the patient's physician, but refused by the patient, patient's family, or guardian; refusal noted in patient record
88	Transplant and/or endocrine surgery/radiation recommended, but it is unknown if it was administered
99	It is unknown whether transplant and/or endocrine surgery/radiation was recommended or administered; death certificate only cases

60440 - RX SUMM--CHEMO

Field Length: 2

This is a calculated field which records chemotherapy given at any facility as part of the first course of treatment, or the reason chemotherapy was not given.

Code	Description
00	None, chemotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Chemotherapy administered as part of first course therapy, but the type and number of agents is not documented.
02	Single-agent chemotherapy administered as first course therapy.
03	Multi-agent chemotherapy administered as first course therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors.
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in the 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 the patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether chemotherapy was recommended or administered because it is not stated in the patient record. Death certificate only.

60450 - RX SUMM--HORMONE

Field Length: 2

This is a calculated field which records whether systemic hormonal agents were administered at any facility as first course treatment, or the reason they were not given.

Code	Description
00	None, hormone therapy was not administered as part of first course treatment. Diagnosed at autopsy.
01	Hormone therapy was given as first course therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors.
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 first course therapy. No reason was stated in the patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but 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 hormone therapy was recommended or administered because it is not stated in the patient record. Death certificate only.

60460 - Rx Summ--BRM

Field Length: 2

This is a calculated field which records whether immunotherapeutic (biologic response modifiers) were administered at any facility as part of first course treatment, or the reason they were not given.

Code	Description
00	None, immunotherapy was not administered as part of first course treatment. Diagnosed at autopsy.
01	Immunotherapy was given as first course therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors.
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 first course therapy. No reason was stated in the patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but 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 immunotherapy was recommended or administered because it is not stated in the patient record. Death certificate only.

60470 - RX SUMM--OTHER

Field Length: 1

This is a calculated field which identifies other treatment given at any facility that cannot be defined as surgery, radiation, or systemic therapy, or the reason such treatment was not administered.

Code	Description
0	None. All cancer treatment was coded in other treatment fields. Diagnosed at autopsy.
1	Cancer treatment that cannot be assigned to other fields was given. Use this code for treatment unique to hematopoietic diseases.
2	Patient received treatment as part of an institution based clinical trial.
3	Patient received treatment as part of a double-blind clinical trial. Code the treatment actually administered when the double-blind code is broken.
6	Cancer treatments administered by nonmedical personnel.
7	Other treatment was not administered. It was recommended by the patient's physician, but was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
8	Other treatment was recommended, but it is unknown whether it was administered.
9	It is unknown whether other treatment was recommended or administered because it is not stated in the patient record. Death certificate only.

60480 - Reason No Radiation

Field Length: 1

This is a calculated field which records the reason the patient did not receive radiation therapy as part of the first course of treatment.

Code	Description
0	Radiation therapy was administered.
1	Radiation therapy not administered because it was not part of the planned first course treatment.
2	Radiation therapy was not recommended/administered because it was contraindicated due to patient risk factors.
5	Radiation therapy was not administered because the patient died prior to planned or recommended treatment.
6	Radiation therapy was recommended by the patient's physician, but was not administered. No reason was noted in the patient's record.
7	Radiation therapy was recommended by the patient's physician, but was refused by the patient, patient's family member, or guardian. Refusal was noted in the patient record.
8	Radiation therapy was recommended, but it is unknown if it was administered.
9	It is unknown if radiation therapy was recommended or performed. Death certificate only cases.

60490 - Rad--Regional Dose: CGY

Field Length: 5

This is a calculated field which records the dominant or most clinically significant total dose of regional radiation therapy delivered to the patient during the first course of treatment. The unit of measure is centiGray (cGy).

Special codes

Code	Description
00000	Radiation therapy was not administered
88888	Brachytherapy or radioisotopes
99999	Radiation therapy administered, but dose unknown

60500 - Rad--No of Treatment Vol

Field Length: 3

This is a calculated field which records the actual number of treatment sessions (fractions) administered during the first course of therapy.

Code	Description
000	None
001-998	Number of treatments
999	Unknown

60510 - Rad--Treatment Volume

Field Length: 2

This is a calculated field which identifies the volume or anatomic target of the most clinically significant regional radiation therapy delivered to the patient during the first course of therapy.

Code	Description
00	Radiation therapy not given
01	Eye/orbit
02	Pituitary
03	Brain (NOS)
04	Brain (limited)
05	Head and neck (NOS)
06	Head and neck (limited)
07	Glottis
08	Sinuses
09	Parotid
10	Chest/lung (NOS)
11	Lung (limited)
12	Esophagus
13	Stomach
14	Liver
15	Pancreas
16	Kidney
17	Abdomen (NOS)
18	Breast
19	Breast/lymph nodes
20	Chest wall
21	Chest wall/lymph nodes
22	Mantle, mini-mantle
23	Lower extended field
24	Spine
25	Skull
26	Ribs
27	Hip
28	Pelvic bones
29	Pelvis (NOS)
30	Skin

31	Soft tissue
32	Hemibody
33	Whole body
34	Bladder and pelvis
35	Prostate and pelvis
36	Uterus and cervix
37	Shoulder
38	Extremities bone, NOS
39	Inverted Y
40	Spinal cord
41	Prostate
50	Thyroid
60	Lymph node region, NOS
98	Other volume
99	Unknown volume; unknown if radiation therapy given

60520 - Rad--Location of Rx

Field Length: 1

This is a calculated field which identifies the location of the facility where radiation treatment was administered during first course of treatment.

Code	Description
0	No radiation therapy; autopsy only
1	All radiation therapy at this facility
2	Regional treatment at this facility, boost elsewhere
3	Boost at this facility, regional elsewhere
4	All radiation therapy elsewhere
8	Other, NOS
9	Unknown

60530 - Rad--Regional Rx Modality

Field Length: 2

This is a calculated field which records the dominant modality of radiation therapy used to deliver the clinically most significant regional dose to the primary volume of interest during the first course of treatment.

Code	Description
00	No radiation therapy given
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 w/o photons/electrons
31	IMRT
32	Conformational or 3-D therapy
40	Protons
41	Stereotactic radiosurgery, NOS
42	Linac radiosurgery
43	Gamma knife
50	Brachytherapy, NOS
51	Brachytherapy, intracavitary, low dose rate (LDR)
52	Brachytherapy, intracavitary, high dose rate (HDR)
53	Brachytherapy, interstitial, low dose rate (LDR)
54	Brachytherapy, interstitial, high does rate (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

60540 - Rad--Boost Rx Modality

Field Length: 2

This is a calculated field which records 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.

Code	Description
00	No boost treatment given
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 w/o photons/electrons
31	IMRT
32	Conformational or 3-D therapy
40	Protons
41	Stereotactic radiosurgery, NOS
42	Linac radiosurgery
43	Gamma knife
50	Brachytherapy, NOS
51	Brachytherapy, intracavitary, low dose rate (LDR)
52	Brachytherapy, intracavitary, high dose rate (HDR)
53	Brachytherapy, interstitial, low dose rate (LDR)
54	Brachytherapy, interstitial, high does rate (HDR)
55	Radium
60	Radioisotopes, NOS
61	Strontium-89
62	Strontium-90
98	Other, NOS
99	Unknown

60550 - Rad--Boost Dose CGY

Field Length: 5

This is a calculated field which records the additional dose delivered to that part of the treatment volume encompassed by the boost fields or devices. The unit of measure is centiGray (cGy).

Code	Description
00000	Boost radiation was not administered
88888	Brachytherapy or radioisotopes administered
99999	Boost radiation administered, dose unknown

60560 - Rx Summ--Systemic Surg Seq

Field Length: 1

This is a calculated field which records the sequencing of systemic therapy and surgical procedures given as part of the first course of treatment. Surgery may be to the primary site, regional lymph nodes, or other site(s).

Code	Description
0	No systemic therapy and/or no surgical procedure
2	Systemic therapy before surgery
3	Systemic therapy after surgery
4	Systemic therapy both before and after surgery
5	Intraoperative systemic therapy
6	Intraoperative systemic therapy with other therapy given before or after surgery
9	Both surgery and systemic therapy given, but sequence unknown

60570 - Rx Summ--Surgery Type

Field Length: 2

This is a calculated field which records site specific surgery codes for cases diagnosed prior to 1996.

60580 - Readm Same Hosp 30 Days

Field Length: 1

This is a calculated field which records a readmission to the same hospital within 30 days of discharge following hospitalization for surgical resection of the primary site.

Code	Description
0	No surgical procedure of the primary site was performed, or the patient was not readmitted to the same hospital within 30 days of discharge.
1	A patient was surgically treated and was readmitted to the same hospital within 30 days of being discharged. This readmission was unplanned.
2	A patient was surgically treated and was then readmitted to the same hospital within 30 days of being discharged. This readmission was planned (chemotherapy port insertion, revision of colostomy, etc.)
3	A patient was surgically treated and, within 30 days of being discharged, the patient had both a planned and an unplanned readmission to the same hospital.
9	It is unknown whether surgery of the primary site was recommended or performed. It is unknown whether the patient was readmitted to the same hospital within 30 days of discharge. Death certificate only.

60590 - Rx Summ--Surg Site 98-02

Field Length: 2

This field only applies to cases diagnosed prior to January 1, 2003. This is a calculated field which records the site-specific surgery code for the type of surgery to the primary site performed as part of the first course of treatment.

Special codes

Code	Description
00	No surgery to the primary site
99	Unknown if surgery performed

60600 - Rx Summ--Scope Reg 98-02

Field Length: 1

This field only applies to cases diagnosed prior to January 1, 2003. It is a calculated field which records the removal, biopsy, or aspiration of regional lymph node(s). See the ROADS Manual for site-specific codes.

60610 - Rx Summ-- Surg Oth 98-02

Field Length: 1

This field only applies to cases diagnosed prior to January 1, 2003. It is a calculated field which records the surgical removal of distant lymph node(s) or other tissue(s)/organ(s) beyond the primary site as part of the first course of treatment. See the ROADS Manual for site-specific codes.

Appendices

APPENDIX A - MULTIPLE PRIMARY RULES FOR HEMATOLOGIC MALIGNANCIES

For the Multiple Primary Determination tables for hematologic malignancies diagnosed between January 1, 2001 and December 31, 2009, click on the link below to go to the SEER web site:

http://seer.cancer.gov/icd-o-3/hematopoietic_primaries.d03152001.pdf

For the Multiple Primary Determination tables for hematologic malignancies diagnosed before January 1, 2001, go to:

http://www.seer.cancer.gov/manuals/codeman.pdf and go to page 22.

APPENDIX B - ABBREVIATIONS FOR US STATES AND FOR PROVINCES OF CANADA AND CORRESPONDING COUNTRIES

The SEER Geocodes can be found

at: http://seer.cancer.gov/manuals/2015/SPCSM_2015_AppendixB.pdf

APPENDIX C - SITE GROUPS AND CORRESPONDING ICD-O CODES

#	Site Group Name	Valid ICD-O Topography Codes	Valid ICD-O-3 Morphology Codes	Valid ICD-O-3 Behavior Codes
01	Lip	C00.0 - C00.9	any valid code EXCEPT lymphomas and melanomas & plasma cell tumors	2, 3
02	Tongue	C01.9 - C02.9	"	2, 3
03	Salivary Glands	C07.9, C08.0 - C08.9	"	2, 3
04	Gum & Hard Palate	C03.0 - C03.9, C05.0 C05.8, C05.9, C06.2	"	2, 3
05	Floor of Mouth	C04.0 - C04.9	"	2, 3
06	Buccal Mucosa	C06.0, C06.1, C06.8 C06.9	"	2, 3
07	Oropharynx	C05.1, C05.2, C09.0 - C09.9 C10.0 - C10.9	"	2, 3
08	Nasopharynx	C11.0 - C11.9	"	2, 3
09	Hypopharynx	C12.9, C13.0 - C13.9	"	2, 3
10	Other Oral Cavity	C14.0 - C14.8	"	2, 3
11	Esophagus	C15.0 - C15.9	"	2, 3
12	Stomach	C16.0 - C16.9	"	2, 3
13	Small Intestine	C17.0 - C17.9	"	2, 3

14	Colon	C18.0 - C18.9	"	2, 3
15	Rectum/Anus	C19.9, C20.9, C21.0 - C21.8	"	2, 3
16	Liver	C22.0 - C22.1	"	2, 3
17	Gallbladder	C23.9 - C24.9	"	2, 3
18	Pancreas	C25.0 - C25.9	"	2, 3
19	Other Digestive Tract	C48.0 - C48.8 C26.0 - C26.9	Any valid code except lymphoma, melanoma, and plasma cell tumors	2, 3
20	Nasal Cavities, Sinuses & Ear	C30.0 - C30.1 C31.0 - C31.9	any valid code EXCEPT lymphomas and melanomas and plasma cell tumors	2, 3
21	Larynx	C32.0 - C32.9	"	2, 3
22	Trachea, Bronchus and Lung - Small Cell	C33.9, C34.0 - C34.9	8041/3, 8042/3, 8043/3, 8044/3, 8045/3, 8073/3	2, 3
23	Trachea, Bronchus and Lung - Non-Small Cell	C33.9, C34.0 - C34.9,	any valid code EXCEPT small cell carcinoma lymphomas, melanomas, and plasma cell tumors	2, 3
24	Other Respiratory Sites	C38.0 - C38.8 C37.9, C39.0 - C39.9	any valid code EXCEPT melanomas, lymphomas, and plasma cell tumors	2, 3

25	Bone	C40.0 - C40.9 C41.0 - C41.9	any valid code except lymphomas, plasma cell tumors	2, 3
26	Connective & Soft Tissue	C47.0 - C47.9 C49.0 - C49.9 C42.2	Any valid code except lymphomas, melanomas, plasma cell tumors	2, 3
27	Malignant Melanoma	C44.0 - C44.9 or any other valid site, i.e., C51.0 - C51.2, C60.0, C60.9, C69.0 - C69.9, etc.	8720 - 8790	2, 3
28	Other Skin	C44.0 - C44.9	any valid code except lymphomas, melanomas, and plasma cell tumors	2, 3
29	Breast (Male & Female)	C50.0 - C50.9	any valid code EXCEPT lymphomas and melanomas and plasma cell tumors	2, 3
30	Cervix	C53.0 - C53.9	"	3
31	Endometrium (Corpus Uteri)	C54.0 - C54.9	"	2, 3
32	Ovary	C56.9	"	2, 3
33	Other Female Genital Organs	C52.9, C55.9, C58.9, C57.0 - C57.9, C51.0 - C51.9	"	2, 3

34	Prostate	C61.9	"	2, 3
35	Testis	C62.0 - C62.9	"	2, 3
36	Other Male Genital Organs	C60.0 - C60.9 C63.0 - C63.9	"	2, 3
37	Bladder	C67.0 - C67.9	"	2, 3
38	Kidney	C64.9	"	2, 3
39	Other Urinary Organs	C65.9, C66.9, C68.0 - C68.9	"	2, 3
40	Eye	C69.0 - C69.9	"	2, 3
41	Brain	C71.0 - C71.9	"	2, 3
42	Other CNS	C70.0 - C70.9 C72.0 - C72.9	"	2, 3
43	Thyroid	C73.9	"	2, 3
44	Other Endocrine	C74.0 - C74.9 C75.0 - C75.9	"	2, 3
45	Hodgkin's	C77.0 - C77.9 or any valid extranodal site	9650/3-9667/3	3
46	Non-Hodgkin's Lymphomas	C77.0 - C77.9 or any valid code	9590/3-9596/3, 9670/3-9699/3, 9702/3-9719/3, 9727/3-9729/3, and 9827/3 unless w/C42.__	3
47	Plasma Cell Tumors	C42.0 - C42.4 or any valid code	9731/3-9734/3	3
48	Lymphoid Leukemias	C42.0 - C42.4	9820/3-9826/3, 9832/3-9837/3, 9827/3, if w/C42.__	3

49	Myeloid Leukemias	C42.0 - C42.4	9840/3-9931/3	3
50	Other Leukemias	C42.0 - C42.4	9742/3, 9800/3-9805/3, 9940/3-9948/3	3
51	Myeloproliferative, Myelodysplastic Diseases	C42.0 - C42.4	9950/3-9989/3	3
52	Other Hematopoietic Diseases	C42.0 - C42.4, C44.0 - C44.9 for mycosis fungoides, C17.0 - C17.9 for Mediterranean lymphoma	9700/3, 9701/3, 9740/3, 9741/3, 9750/3-9758/3, 9760/3-9769/3	3
53	Other and Ill-Defined Sites	C76.0 - C76.8	any valid code EXCEPT lymphomas and melanomas and plasma cell tumors	2, 3
54	Unknown Primary	C80.9	"	3
55	Cannot determine site group from information available. (Use only when recording other primaries.)			
60	Benign & borderline intracranial tumors	C70.0 - C72.9, C75.1 - C75.3	any valid code	0, 1

CPDMS SITE GROUP CODE ASSIGNMENT
By Topography and Histology
(revised May 2004)

Melanomas (Group 27) 8720-8790 Hodgkin's Lymphomas (Group 45) 9650-9667 NonHodgkin's Lymphomas (Group 46) 9590-9596 9727-9729 9670-9699 9827 unless with C42 9702-9719	Leukemias 9800-9827 9831-9920 9931-9948	Plasma cell tumors (Group 47) 9731-9734 Other Hematopoietic Dz (Grp 52) 9700-9701 9750-9758 9740-9741 9760-9769
IF TOPOGRAPHY=	**AND HISTOLOGY=**	**THEN SITE GROUP CODE=**
C00.0 - C00.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 01
C01.9 - C02.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 02
C07.9 - C08.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 03
C03.0 - C03.9	8720-8790	Group 27

C05.0, C05.8, C05.9, C06.2	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 04
C04.0 - C04.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 05
C06.0 - C06.1 C06.8 - C06.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 06
C05.1 - C05.2, C09.0 - C09.9, C10.0 - C10.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 07
C11.0 - C11.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 08
C12.9 - C13.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 09

C14.0 - C14.8	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 10
C15.0 - C15.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 11
C16.0 - C16.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 12
C17.0 - C17.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 13
C18.0 - C18.9	8090-8098	Not valid
	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 14
C19.9 - C21.8	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid

	9930	Group 49
	else	Group 15
C22.0 - C22.1	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 16
C23.9 - C24.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 17
C25.0 - C25.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 18
C26.0 - C26.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 19
C30.0 - C31.9	9250-9342	Not valid
	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 20
C32.0 - C32.9	9250-9342	Not valid
	8720-8790	Group 27

	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 21
C33.9 - C34.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	8041-8045, 8073	Group 22
	Leukemia	Not valid
	9930	Group 49
	else	Group 23
C37.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 24
C38.0 - C38.8	8010-8671	Not valid
	8940-8941	Not valid
	8720-8790	Not valid
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 24
C39.0 - C39.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 24
C40.0 - C41.9	8010-8050	Not valid
	8052-8060	Not valid
	8075-8671	Not valid

	8720-8790	Not valid
	8940-8941	Not valid
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 25
C42.0 - C42.4	8801, 9120, 9133	Group 26
	9731-9734	Group 47
	9820-9827	Group 48
	9831-9837	Group 48
	9840-9931	Group 49
	9742, 9800-9805	Group 50
	9940-9948	Group 50
	9950-9989	Group 51
	Lymphoma	Group 45, 46, or 52
	else	Not valid
C44.0 - C44.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 28
C47.0 - C47.9	8010-8671	Not valid
	8940-8941	Not valid
	9731-9734	Group 47
	8720-8790	Not valid
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 26
C49.0 - C49.9	9731-9734	Group 47
	8720-8790	Not valid
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid

	9930	Group 49
	else	Group 26
C48.0 - C48.8	Lymphoma	Group 45, 46, or 52
	8720-8790	Not valid
	9731-9734	Group 47
	Leukemia	Not valid
	9930	Group 49
	else	Group 19
C50.0 - C50.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 29
C53.0 - C53.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 30
C54.0 - C54.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 31
C56.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 32
C51.0 - C51.9 C52.9, C55.9, C58.9 C57.0 - C57.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52

	Leukemia	Not valid
	9930	Group 49
	else	Group 33
C61.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 34
C62.0 - C62.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 35
C60.0 - C60.9 C63.0 - C63.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 36
C67.0 - C67.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 37
C64.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 38
C65.9, C66.9 C68.0 - C68.9	8720-8790	Group 27
	9731-9734	Group 47

	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 39
C69.0 - C69.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 40
C71.0 - C71.9	8940-8941	Not valid
	8010-8671	Not valid
	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	with behavior = 0, 1	Group 60
	else	Group 41
C70.0 - C70.9 C72.0 - C72.9	8940-8941	Not valid
	8010-8671	Not valid
	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	with behavior = 0, 1	Group 60
	else	Group 42
C73.9	8720-8790	Group 27
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	else	Group 43
C74.0 - C74.9	8720-8790	Group 27

C75.0 - C75.9	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Group 49
	if behavior = 0,1	Group 60
	else	Group 44
C77.0 - C77.9	Lymphoma	Group 45, 46, or 52
	9731-9734	Group 47
	Leukemia	Not valid
	9930	Group 49
	else	Not valid
C76.0 - C76.8	8800-8833	Not valid
	8840-8921	Not valid
	9040-9044	Not valid
	8990-8991	Not valid
	8940-8941	Not valid
	9120-9175	Not valid
	9240-9252	Not valid
	9540-9560	Not valid
	9580-9582	Not valid
	8720-8790	Not valid
	Lymphoma	Group 45, 46, or 52
	9731-9734	Group 47
	Leukemia	Not valid
	9930	Group 49
	else	Group 53
C80.9	8720-8790	Not valid
	9731-9734	Group 47
	Lymphoma	Group 45, 46, or 52
	Leukemia	Not valid
	9930	Not valid
	else	Group 54

APPENDIX D - CITIES, ZIP CODES, AND COUNTIES

The U.S. Postal Service web site has a search feature which allows users to search for ZIP codes by address or by city, and to list all cities within a particular ZIP code. The URL is http://zip4.usps.com/zip4/welcome.jsp. To determine which county a particular address is in, use the "Search By Address" tool. Enter the street address, city, and state, and then click "Submit." Once the results are displayed, click on the link to the right labeled "Mailing Industry Information" to see the county.

County FIPS	County Name	ADD	Urban/Rural	Beale Code	App/non-App
21001	Adair	Lake Cumberland	Rural	7	Appalachia
21003	Allen	Barren River	Rural	6	Non-Appalachia
21005	Anderson	Bluegrass	Rural	6	Non-Appalachia
21007	Ballard	Purchase	Rural	9	Non-Appalachia
21009	Barren	Barren River	Rural	6	Non-Appalachia
21011	Bath	Gateway	Rural	8	Appalachia
21013	Bell	Cumberland Valley	Rural	7	Appalachia
21015	Boone	Northern Kentucky	Urban	1	Non-Appalachia
21017	Bourbon	Bluegrass	Urban	2	Non-Appalachia
21019	Boyd	Fivco	Urban	2	Appalachia
21021	Boyle	Bluegrass	Rural	7	Non-Appalachia
21023	Bracken	Buffalo Trace	Urban	1	Non-Appalachia
21025	Breathitt	Kentucky River	Rural	7	Appalachia
21027	Breckinridge	Lincoln Trail	Rural	8	Non-Appalachia
21029	Bullitt	Kipda	Urban	1	Non-Appalachia
21031	Butler	Barren River	Rural	8	Non-Appalachia
21033	Caldwell	Pennyrile	Rural	6	Non-Appalachia
21035	Calloway	Purchase	Rural	7	Non-Appalachia
21037	Campbell	Northern Kentucky	Urban	1	Non-Appalachia
21039	Carlisle	Purchase	Rural	9	Non-Appalachia
21041	Carroll	Northern Kentucky	Rural	6	Non-Appalachia
21043	Carter	Fivco	Rural	6	Appalachia
21045	Casey	Lake Cumberland	Rural	9	Appalachia
21047	Christian	Pennyrile	Urban	3	Non-Appalachia
21049	Clark	Bluegrass	Urban	2	Appalachia
21051	Clay	Cumberland Valley	Rural	7	Appalachia
21053	Clinton	Lake Cumberland	Rural	9	Appalachia

21055	Crittenden	Pennyrile	Rural	6	Non-Appalachia
21057	Cumberland	Lake Cumberland	Rural	9	Appalachia
21059	Daviess	Green River	Urban	3	Non-Appalachia
21061	Edmonson	Barren River	Urban	3	Appalachia
21063	Elliott	Fivco	Rural	9	Appalachia
21065	Estill	Bluegrass	Rural	6	Appalachia
21067	Fayette	Bluegrass	Urban	2	Non-Appalachia
21069	Fleming	Buffalo Trace	Rural	7	Appalachia
21071	Floyd	Big Sandy	Rural	7	Appalachia
21073	Franklin	Bluegrass	Rural	4	Non-Appalachia
21075	Fulton	Purchase	Rural	7	Non-Appalachia
21077	Gallatin	Northern Kentucky	Urban	1	Non-Appalachia
21079	Garrard	Bluegrass	Rural	6	Appalachia
21081	Grant	Northern Kentucky	Urban	1	Non-Appalachia
21083	Graves	Purchase	Rural	7	Non-Appalachia
21085	Grayson	Lincoln Trail	Rural	6	Non-Appalachia
21087	Green	Lake Cumberland	Rural	8	Appalachia
21089	Greenup	Fivco	Urban	2	Appalachia
21091	Hancock	Green River	Urban	3	Non-Appalachia
21093	Hardin	Lincoln Trail	Urban	3	Non-Appalachia
21095	Harlan	Cumberland Valley	Rural	7	Appalachia
21097	Harrison	Bluegrass	Rural	6	Non-Appalachia
21099	Hart	Barren River	Rural	8	Appalachia
21101	Henderson	Green River	Urban	2	Non-Appalachia
21103	Henry	Kipda	Urban	1	Non-Appalachia
21105	Hickman	Purchase	Rural	9	Non-Appalachia
21107	Hopkins	Pennyrile	Rural	4	Non-Appalachia
21109	Jackson	Cumberland Valley	Rural	9	Appalachia
21111	Jefferson	Kipda	Urban	1	Non-Appalachia
21113	Jessamine	Bluegrass	Urban	2	Non-Appalachia
21115	Johnson	Big Sandy	Rural	7	Appalachia
21117	Kenton	Northern Kentucky	Urban	1	Non-Appalachia
21119	Knott	Kentucky River	Rural	9	Appalachia
21121	Knox	Cumberland Valley	Rural	7	Appalachia
21123	Larue	Lincoln Trail	Urban	3	Non-Appalachia
21125	Laurel	Cumberland Valley	Rural	7	Appalachia
21127	Lawrence	Fivco	Rural	6	Appalachia

21129	Lee	Kentucky River	Rural	9	Appalachia
21131	Leslie	Kentucky River	Rural	9	Appalachia
21133	Letcher	Kentucky River	Rural	9	Appalachia
21135	Lewis	Buffalo Trace	Rural	8	Appalachia
21137	Lincoln	Bluegrass	Rural	7	Appalachia
21139	Livingston	Pennyrile	Rural	9	Non-Appalachia
21141	Logan	Barren River	Rural	6	Non-Appalachia
21143	Lyon	Pennyrile	Rural	8	Non-Appalachia
21145	McCracken	Purchase	Rural	5	Non-Appalachia
21147	McCreary	Lake Cumberland	Rural	9	Appalachia
21149	McLean	Green River	Urban	3	Non-Appalachia
21151	Madison	Bluegrass	Rural	4	Appalachia
21153	Magoffin	Big Sandy	Rural	9	Appalachia
21155	Marion	Lincoln Trail	Rural	6	Non-Appalachia
21157	Marshall	Purchase	Rural	7	Non-Appalachia
21159	Martin	Big Sandy	Rural	8	Appalachia
21161	Mason	Buffalo Trace	Rural	6	Non-Appalachia
21163	Meade	Lincoln Trail	Urban	1	Non-Appalachia
21165	Menifee	Gateway	Rural	9	Appalachia
21167	Mercer	Bluegrass	Rural	6	Non-Appalachia
21169	Metcalfe	Barren River	Rural	9	Appalachia
21171	Monroe	Barren River	Rural	9	Appalachia
21173	Montgomery	Gateway	Rural	6	Appalachia
21175	Morgan	Gateway	Rural	7	Appalachia
21177	Muhlenberg	Pennyrile	Rural	6	Non-Appalachia
21179	Nelson	Lincoln Trail	Urban	1	Non-Appalachia
21181	Nicholas	Bluegrass	Rural	8	Appalachia
21183	Ohio	Green River	Rural	6	Non-Appalachia
21185	Oldham	Kipda	Urban	1	Non-Appalachia
21187	Owen	Northern Kentucky	Rural	8	Non-Appalachia
21189	Owsley	Kentucky River	Rural	9	Appalachia
21191	Pendleton	Northern Kentucky	Urban	1	Non-Appalachia
21193	Perry	Kentucky River	Rural	7	Appalachia
21195	Pike	Big Sandy	Rural	7	Appalachia
21197	Powell	Bluegrass	Rural	6	Appalachia
21199	Pulaski	Lake Cumberland	Rural	5	Appalachia
21201	Robertson	Buffalo Trace	Rural	8	Appalachia

21203	Rockcastle	Cumberland Valley	Rural	7	Appalachia
21205	Rowan	Gateway	Rural	7	Appalachia
21207	Russell	Lake Cumberland	Rural	9	Appalachia
21209	Scott	Bluegrass	Urban	2	Non-Appalachia
21211	Shelby	Kipda	Urban	1	Non-Appalachia
21213	Simpson	Barren River	Rural	6	Non-Appalachia
21215	Spencer	Kipda	Urban	1	Non-Appalachia
21217	Taylor	Lake Cumberland	Rural	7	Non-Appalachia
21219	Todd	Pennyrile	Rural	8	Non-Appalachia
21221	Trigg	Pennyrile	Urban	3	Non-Appalachia
21223	Trimble	Kipda	Urban	1	Non-Appalachia
21225	Union	Green River	Rural	6	Non-Appalachia
21227	Warren	Barren River	Urban	3	Non-Appalachia
21229	Washington	Lincoln Trail	Rural	8	Non-Appalachia
21231	Wayne	Lake Cumberland	Rural	7	Appalachia
21233	Webster	Green River	Urban	2	Non-Appalachia
21235	Whitley	Cumberland Valley	Rural	7	Appalachia
21237	Wolfe	Kentucky River	Rural	9	Appalachia
21239	Woodford	Bluegrass	Urban	2	Non-Appalachia

CODES FOR COUNTIES IN THE STATES BORDERING KENTUCKY

ILLINOIS 17

CODE	**COUNTY NAME**
001	Adams
003	Alexander
005	Bond
007	Boone
009	Brown
011	Bureau
013	Calhoun
015	Carroll
017	Cass
019	Champaign
021	Christian
023	Clark
025	Clay
027	Clinton
029	Coles

031	Cook
033	Crawford
035	Cumberland
037	DeKalb
039	De Witt
041	Douglas
043	DuPage
045	Edgar
047	Edwards
049	Effingham
051	Fayette
053	Ford
055	Franklin
057	Fulton
059	Gallatin
061	Greene
063	Grundy
065	Hamilton
067	Hancock
069	Hardin
071	Henderson
073	Henry
075	Iroquois
077	Jackson
079	Jasper
081	Jefferson
083	Jersey
085	Jo Daviess
087	Johnson
089	Kane
091	Kankakee
093	Kendall
095	Knox
097	Lake
099	La Salle
101	Lawrence
103	Lee
105	Livingston
107	Logan
109	McDonough
111	McHenry
113	McLean
115	Macon
117	Macoupin
119	Madison

121	Marion
123	Marshall
125	Mason
127	Massac
129	Menard
131	Mercer
133	Monroe
135	Montgomery
137	Morgan
139	Moultrie
141	Ogle
143	Peoria
145	Perry
147	Piatt
149	Pike
151	Pope
153	Pulaski
155	Putnam
157	Randolph
159	Richland
161	Rock Island
163	St. Clair
165	Saline
167	Sangamon
169	Schuyler
171	Scott
173	Shelby
175	Stark
177	Stephenson
179	Tazewell
181	Union
183	Vermilion
185	Wabash
187	Warren
189	Washington
191	Wayne
193	White
195	Whiteside
197	Will
199	Williamson
201	Winnebago
203	Woodford

INDIANA 18

CODE	**COUNTY NAME**

001	Adams
003	Allen
005	Bartholomew
007	Benton
009	Blackford
011	Boone
013	Brown
015	Carroll
017	Cass
019	Clark
021	Clay
023	Clinton
025	Crawford
027	Daviess
029	Dearborn
031	Decatur
033	DeKalb
035	Delaware
037	Dubois
039	Elkhart
041	Fayette
043	Floyd
045	Fountain
047	Franklin
049	Fulton
051	Gibson
053	Grant
055	Greene
057	Hamilton
059	Hancock
061	Harrison
063	Hendricks
065	Henry
067	Howard
069	Huntington
071	Jackson
073	Jasper
075	Jay
077	Jefferson
079	Jennings
081	Johnson
083	Knox
085	Kosciusko
087	Lagrange
089	Lake

091	LaPorte
093	Lawrence
095	Madison
097	Marion
099	Marshall
101	Martin
103	Miami
105	Monroe
107	Montgomery
109	Morgan
111	Newton
113	Noble
115	Ohio
117	Orange
119	Owen
121	Parke
123	Perry
125	Pike
127	Porter
129	Posey
131	Pulaski
133	Putnam
135	Randolph
137	Ripley
139	Rush
141	St. Joseph
143	Scott
145	Shelby
147	Spencer
149	Starke
151	Steuben
153	Sullivan
155	Switzerland
157	Tippecanoe
159	Tipton
161	Union
163	Vanderburgh
165	Vermillion
167	Vigo
169	Wabash
171	Warren
173	Warrick
175	Washington
177	Wayne
179	Wells

181	White
183	Whitley

MISSOURI 29

CODE	COUNTY NAME
001	Adair
003	Andrew
005	Atchison
007	Audrain
009	Barry
011	Barton
013	Bates
015	Benton
017	Bollinger
019	Boone
021	Buchanan
023	Butler
025	Caldwell
027	Callaway
029	Camden
031	Cape Girardeau
033	Carroll
035	Carter
037	Cass
039	Cedar
041	Chariton
043	Christian
045	Clark
047	Clay
049	Clinton
051	Cole
053	Cooper
055	Crawford
057	Dade
059	Dallas
061	Daviess
063	DeKalb
065	Dent
067	Douglas
069	Dunklin
071	Franklin
073	Gasconade
075	Gentry
077	Greene
079	Grundy

081	Harrison
083	Henry
085	Hickory
087	Holt
089	Howard
091	Howell
093	Iron
095	Jackson
097	Jasper
099	Jefferson
101	Johnson
103	Knox
105	Laclede
107	Lafayette
109	Lawrence
111	Lewis
113	Lincoln
115	Linn
117	Livingston
119	McDonald
121	Macon
123	Madison
125	Maries
127	Marion
129	Mercer
131	Miller
133	Mississippi
135	Moniteau
137	Monroe
139	Montgomery
141	Morgan
143	New Madrid
145	Newton
147	Nodaway
149	Oregon
151	Osage
153	Ozark
155	Pemiscot
157	Perry
159	Pettis
161	Phelps
163	Pike
165	Platte
167	Polk
169	Pulaski

171	Putnam
173	Ralls
175	Randolph
177	Ray
179	Reynolds
181	Ripley
183	St. Charles
185	St. Clair
186	St. Genevieve
187	St. Francois
189	St. Louis County
195	Saline
197	Schuyler
199	Scotland
201	Scott
203	Shannon
205	Shebly
207	Stoddard
209	Stone
211	Sullivan
213	Taney
215	Texas
217	Vernon
219	Warren
221	Washington
223	Wayne
225	Webster
227	Worth
229	Wright

OHIO 39

CODE	**COUNTY NAME**
001	Adams
003	Allen
005	Ashland
007	Ashtabula
009	Athens
011	Auglaize
013	Belmont
015	Brown
017	Butler
019	Carroll
021	Champaign
023	Clark
025	Clermont

027	Clinton
029	Columbiana
031	Coshocton
033	Crawford
035	Cuyahoga
037	Darke
039	Defiance
041	Delaware
043	Erie
045	Fairfield
047	Fayette
049	Franklin
051	Fulton
053	Gallia
055	Geauga
057	Greene
059	Guernsey
061	Hamilton
063	Hancock
065	Hardin
067	Harrison
069	Henry
071	Highland
073	Hocking
075	Holmes
077	Huron
079	Jackson
081	Jefferson
083	Knox
085	Lake
087	Lawrence
089	Licking
091	Logan
093	Lorain
095	Lucas
097	Madison
099	Mahoning
101	Marion
103	Medina
105	Meigs
107	Mercer
109	Miami
111	Monroe
113	Montgomery
115	Morgan

117	Morrow
119	Muskingum
121	Noble
123	Ottawa
125	Paulding
127	Perry
129	Pickaway
131	Pike
133	Portage
135	Preble
137	Putnam
139	Richland
141	Ross
143	Sandusky
145	Scioto
147	Seneca
149	Shelby
151	Stark
153	Summit
155	Trumbull
157	Tuscarawas
159	Union
161	VanWert
163	Vinton
165	Warren
167	Washington
169	Wayne
171	Williams
173	Wood
175	Wyandot

TENNESSEE 47

CODE	**COUNTY NAME**
001	Anderson
003	Bedford
005	Benton
007	Bledsoe
009	Blount
011	Bradley
013	Campbell
015	Cannon
017	Carroll
019	Carter
021	Cheatham
023	Chester

025	Claiborne
027	Clay
029	Cocke
031	Coffee
033	Crockett
035	Cumberland
037	Davidson
039	Decatur
041	DeKalb
043	Dickson
045	Dyer
047	Fayette
049	Fentress
051	Franklin
053	Gibson
055	Giles
057	Grainger
059	Greene
061	Grundy
063	Hamblen
065	Hamilton
067	Hancock
069	Hardeman
071	Hardin
073	Hawkins
075	Haywood
077	Henderson
079	Henry
081	Hickman
083	Houston
085	Humphreys
087	Jackson
089	Jefferson
091	Johnson
093	Knox
095	Lake
097	Lauderdale
099	Lawrence
101	Lewis
103	Lincoln
105	Loudon
107	McMinn
109	McNairy
111	Macon
113	Madison

115	Marion
117	Marshall
119	Maury
121	Meigs
123	Monroe
125	Montgomery
127	Moore
129	Morgan
131	Obion
133	Overton
135	Perry
137	Pickett
139	Polk
141	Putnam
143	Rhea
145	Roane
147	Robertson
149	Rutherford
151	Scott
153	Sequatchie
155	Sevier
157	Shelby
159	Smith
161	Stewart
163	Sullivan
165	Sumner
167	Tipton
169	Trousdale
171	Unicoi
173	Union
175	Van Buren
177	Warren
179	Washington
181	Wayne
183	Weakley
185	White
187	Williamson
189	Wilson

VIRGINIA 51

CODE	**COUNTY NAME**
001	Accomack
003	Albermarle
005	Alleghany
007	Amelia

009	Amherst
011	Appomattox
013	Arlington
015	Augusta
017	Bath
019	Bedford
021	Bland
023	Botetourt
025	Brunswick
027	Buchanan
029	Buckingham
031	Campbell
033	Caroline
035	Carroll
036	Charles City
037	Charlotte
041	Chesterfield
043	Clarke
045	Craig
047	Culpeper
049	Cumberland
051	Dickenson
053	Dinwiddie
057	Essex
059	Fairfax
061	Fauquier
063	Floyd
065	Fluvanna
067	Franklin
069	Frederick
071	Giles
073	Gloucester
075	Goochland
077	Grayson
079	Greene
081	Greensville
083	Halifax
085	Hanover
087	Henrico
089	Henry
091	Highland
093	Isle of Wight
095	James City
097	King And Queen
099	King George

101	King William
103	Lancaster
105	Lee
107	Loudoun
109	Louisa
111	Lunenburg
113	Madison
115	Mathews
117	Mecklenburg
119	Middlesex
121	Montgomery
125	Nelson
127	New Kent
131	Northampton
133	Northumberland
135	Nottoway
137	Orange
139	Page
141	Patrick
143	Pittsylvania
145	Powhatan
147	Prince Edward
149	Prince George
153	Prince William
155	Pulaski
157	Rappahannock
159	Richmond
161	Roanoke
163	Rockbridge
165	Rockingham
167	Russell
169	Scott
171	Shenandoah
173	Smyth
175	Southampton
177	Spotsylvania
179	Stafford
181	Surry
183	Sussex
185	Tazewell
187	Warren
191	Washington
193	Westmoreland
195	Wise
197	Wythe

199 York

WEST VIRGINIA 54

CODE	COUNTY NAME
001	Barbour
003	Berkeley
005	Boone
007	Braxton
009	Brooke
011	Cabell
013	Calhoun
015	Clay
017	Doddridge
019	Fayette
021	Gilmer
023	Grant
025	Greenbrier
027	Hampshire
029	Hancock
031	Hardy
033	Harrison
035	Jackson
037	Jefferson
039	Kanawha
041	Lewis
043	Lincoln
045	Logan
047	McDowell
049	Marion
051	Marshall
053	Mason
055	Mercer
057	Mineral
059	Mingo
061	Monongalia
063	Monroe
065	Morgan
067	Nicholas
069	Ohio
071	Pendleton
073	Pleasants
075	Pocahontas
077	Preston
079	Putnam
081	Raleigh

083 Randolph
085 Ritchie
087 Roane
089 Summers
091 Taylor
093 Tucker
095 Tyler
097 Upshur
099 Wayne
101 Webster
103 Wetzel
105 Wirt
107 Wood
109 Wyoming

OTHER STATES 00
998 - Known County
999 - Unknown County

APPENDIX E - GENERAL SITES DICTIONARY

The General Site Codes are used for coding several data items: sites of metastases, sites of radiation therapy, and sites of recurrence. The first 44 codes are essentially the same as the first 44 site group codes found in Appendix C, which are based on the ICD-O topography and morphology classifications. General Site Codes from 67 to 99 are additional names of parts of the body that may be useful in coding metastatic or radiation sites.

Code	Description
01	Lip
02	Tongue
03	Salivary Glands
04	Gum/Hard Palate
05	Floor of Mouth
06	Buccal Mucosa
07	Oropharynx
08	Nasopharynx
09	Hypopharynx
10	Other Oral Cavity
11	Esophagus
12	Stomach
13	Small Intestine
14	Colon
15	Rectum/Anus
16	Liver
17	Gallbladder
18	Pancreas
19	Other Digestive Tract
20	Nasal Cavities/Ear
21	Larynx
22	Lung
24	Other Respiratory
25	Bone
26	Connective/Soft Tissue
29	Breast

30	Cervix Uteri
31	Corpus Uteri
32	Ovary
33	Other Female Genital
34	Prostate
35	Testis
36	Other Male Genital
37	Bladder
38	Kidney - Renal Parenchyma
39	Other Urinary Organs
40	Eye
41	Brain
42	Other CNS
43	Thyroid
44	Other Endocrine
66	Skin, NOS
67	Head
68	Neck/Face
69	Mediastinum
71	Arm
72	Axilla
73	Peritoneum
74	Flank
75	Abdomen
76	Pelvis
77	Perineum
78	Bone Marrow
79	Hand
80	Leg
81	Foot
82	Back
83	Mantle - includes cervical, supraclavicular, axillary, hilar, medistinal LN radiation
84	Yoke - Bilateral supraclavicular

85	Lymph nodes
86	Blood
87	Spleen
88	Omentum
89	Retroperitoneum
90	Chest Wall
91	Shoulder
92	Spine
97	Total Body
98	Other Ill-Defined
99	Unknown

APPENDIX F - HEALTHCARE FACILITIES AND IDENTIFICATION NUMBERS

HOSPITALS

Code	Name	City
510088	BAPTIST HEALTH - CORBIN	CORBIN
510373	BAPTIST HEALTH - LA GRANGE	LAGRANGE
510407	BAPTIST HEALTH - LEXINGTON	LEXINGTON
510375	BAPTIST HEALTH - LOUISVILLE	LOUISVILLE
510670	BAPTIST HEALTH - MADISONVILLE	MADISONVILLE
510815	BAPTIST HEALTH - PADUCAH	PADUCAH
510900	BAPTIST HEALTH - RICHMOND	RICHMOND
510175	BLANCHFIELD ARMY COMM. HOSP	FORT CAMPBELL
510956	BLUEGRASS COMMUNITY HOSPITAL	VERSAILLES
510834	BOURBON COMMUNITY HOSPITAL	PARIS
510266	BRECKINRIDGE MEMORIAL HOSPITAL	HARDINSBURG
510874	CALDWELL COUNTY HOSPITAL	PRINCETON
510081	CARROLL CNTY MEMORIAL HOSPITAL	CARROLLTON
510473	CASEY COUNTY WAR MEMORIAL HOSP	LIBERTY
519055	CAVERNA MEMORIAL HOSPITAL	HORSE CAVE
510970	CLARK COUNTY REG MEDICAL CNTR	WINCHESTER
519001	CLINTON CNTY WAR MEMORIAL HOSP	ALBANY
510680	CRITTENDEN HEALTH SYSTEMS	MARION
519020	CUMBERLAND COUNTY HOSPITAL	BURKESVILLE
510140	EPHRAIM MCDOWELL REGIONAL MC	DANVILLE
510048	FLAGET MEMORIAL HOSPITAL	BARDSTOWN
510172	FLEMING COUNTY HOSPITAL	FLEMINGSBURG
510938	FORT LOGAN HOSPITAL	STANFORD
510195	FRANKFORT REGIONAL MED CENTER	FRANKFORT
510395	GARRARD COUNTY MEMORIAL HOSP	LANCASTER
510230	GEORGETOWN COMMUNITY HOSPITAL	GEORGETOWN
510065	GREENVIEW REGIONAL HOSP, HCA	BOWLING GREEN
510165	HARDIN MEMORIAL HOSPITAL	ELIZABETHTOWN

510275	HARLAN APPALACHIAN REG HOSP	HARLAN
510130	HARRISON MEMORIAL HOSPITAL	CYNTHIANA
510287	HAZARD APPALACHIAN REG MED CTR	HAZARD
510875	HIGHLANDS REG MED CTR - NHF	PRESTONSBURG
510873	HIGHLANDS REGIONAL MED CTR	PRESTONSBURG
510695	JACKSON PURCHASE MEDICAL CTR	MAYFIELD
510280	JAMES B HAGGIN MEMORIAL HOSP	HARRODSBURG
510255	JANE TODD CRAWFORD MEM HOSP	GREENSBURG
510358	JENKINS COMMUNITY HOSPITAL	JENKINS
510330	JENNIE STUART MEDICAL CENTER	HOPKINSVILLE
510510	JEWISH HOSPITAL	LOUISVILLE
510920	JEWISH HOSPITAL SHELBYVILLE	SHELBYVILLE
510082	JOHNSON MATHERS HEALTHCARE	CARLISLE
510359	KENTUCKY RIVER MEDICAL CENTER	JACKSON
510040	KING'S DAUGHTERS' MEDICAL CNTR	ASHLAND
510044	KNOX COUNTY GENERAL HOSPITAL	BARBOURVILLE
510485	KOSAIR CHILDREN'S HOSPITAL	LOUISVILLE
510940	LAKE CUMBERLAND REGIONAL HOSP.	SOMERSET
519070	LIVINGSTON COUNTY HOSPITAL	SALEM
510915	LOGAN MEMORIAL HOSP.	RUSSELLVILLE
510810	LOURDES HOSPITAL	PADUCAH
510355	MARCUM & WALLACE MEMORIAL HOSP	IRVINE
510049	MARSHALL COUNTY HOSPITAL	BENTON
510350	MARY BRECKINRIDGE HOSPITAL	HYDEN
510712	MCDOWELL APPALACHIAN REGIONAL	MCDOWELL
510710	MEADOWVIEW HOSPITAL	MAYSVILLE
510070	MED CENTER AT BOWLING GREEN	BOWLING GREEN
510203	MEDICAL CENTER AT FRANKLIN	FRANKLIN
510916	MEDICAL CENTER AT SCOTTSVILLE	SCOTTSVILLE
519065	MEMORIAL HOSPITAL	MANCHESTER
510785	MERCY HOSPITAL	OWENSBORO
510560	METHODIST EVANGELICAL HOSPITAL	LOUISVILLE
510320	METHODIST HOSPITAL	HENDERSON

510715	MIDDLESBORO APPALACHIAN REG	MIDDLESBORO
510947	MONROE COUNTY MEDICAL CENTER	TOMPKINSVILLE
510960	MORGAN COUNTY APP REG HOSP	WEST LIBERTY
510260	MUHLENBERG COMMUNITY HOSPITAL	GREENVILLE
510750	MURRAY-CALLOWAY COUNTY HOSP	MURRAY
510795	NEW HORIZON MEDICAL CENTER	OWENTON
510610	NORTON AUDUBON HOSPITAL	LOUISVILLE
10001050	NORTON BROWNSBORO HOSPITAL	LOUISVILLE
510488	NORTON HOSPITAL	LOUISVILLE
510575	NORTON SOUTHWEST HOSPITAL	LOUISVILLE
510615	NORTON SUBURBAN HOSPITAL	LOUISVILLE
510283	OHIO COUNTY HOSPITAL	HARTFORD
510042	OUR LADY OF BELLEFONTE HOSP	ASHLAND
510790	OWENSBORO MEDICAL HEALTH SYS	OWENSBORO
510220	PARKWAY REGIONAL HOSPITAL	FULTON
510830	PAUL B HALL REGIONAL MED CTR	PAINTSVILLE
510860	PIKEVILLE MEDICAL CENTER	PIKEVILLE
510870	PINEVILLE COMMUNITY HOSPITAL	PINEVILLE
510745	ROCKCASTLE COUNTY HOSPITAL	MOUNT VERNON
511000	RUSSELL COUNTY HOSPITAL	RUSSELL SPRINGS
510420	SAMARITAN HOSPITAL	LEXINGTON
510400	SPRINGVIEW HOSPITAL	LEBANON
510600	ST ANTHONY MEDICAL CENTER	LOUISVILLE
510717	ST CLAIRE MEDICAL CENTER	MOREHEAD
510969	ST ELIZABETH GRANT COUNTY	WILLIAMSTOWN
510110	ST ELIZABETH EDGEWOOD - COVINGTON	COVINGTON
510685	ST JOSEPH MARTIN HOSPITAL	MARTIN
510184	ST ELIZABETH FT THOMAS	FORT THOMAS
510120	ST ELIZABETH FLORENCE	FLORENCE
510050	ST. JOSEPH BEREA HOSPITAL	BEREA
510440	ST. JOSEPH HOSPITAL	LEXINGTON
510435	ST. JOSEPH HOSPITAL EAST	LEXINGTON
510475	ST. JOSEPH LONDON	LONDON
510740	ST. JOSEPH MOUNT STERLING	MOUNT STERLING
510620	STS MARY & ELIZABETH HOSPITAL	LOUISVILLE
510240	T J SAMSON COMMUNITY HOSPITAL	GLASGOW

510076	TAYLOR REGIONAL HOSPITAL	CAMPBELLSVILLE
510477	THREE RIVERS MEDICAL CENTER	LOUISA
510073	TRIGG COUNTY HOSPITAL	CADIZ
510403	TWIN LAKES REGIONAL MED CENTER	LEITCHFIELD
510732	UNION COUNTY METHODIST	MORGANFIELD
510455	UNIVERSITY OF KENTUCKY HOSP	LEXINGTON
510550	UNIVERSITY OF LOUISVILLE HOSP	LOUISVILLE
510180	US IRELAND ARMY COMMUNITY HOSP	FORT KNOX
510470	VA MEDICAL CENTER - LEXINGTON	LEXINGTON
510570	VA MEDICAL CENTER - LOUISVILLE	LOUISVILLE
510708	WAYNE COUNTY HOSPITAL	MONTICELLO
510086	WESTLAKE CUMBERLAND HOSPITAL	COLUMBIA
510967	WHITESBURG APP REG HOSP	WHITESBURG
510935	WILLIAMSON APP REG HOSP	S WILLIAMSON
510950	WOODFORD COUNTY MEMORIAL	VERSAILLES

COMBINED IDS

Code	Name	City
513012	BOWLING GREEN COMBINED	BOWLING GREEN
513014	JEWISH ST MARYS COMBINED	LOUISVILLE
513001	NORTON HEALTHCARE	LOUISVILLE
513009	OWENSBORO MEDICAL HEALTH SYSTEMS	OWENSBORO
513015	ST ELIZABETH HEALTHCARE	COVINGTON
513016	KENTUCKY ONE HEALTH	LEXINGTON
513017	BAPTIST HEALTH CANCER CARE - KY	LOUISVILLE

NON-HOSPITAL FACILITIES

Code	Institution Name	City
518120	ARH CUMBERLAND VALLEY PCC	LYNCH
518096	ASHLAND BELLEFONTE CANCER CTR	ASHLAND
518108	BAPTIST HEALTH CANCER CARE	PADUCAH
518128	BEREA CANCER TREATMENT CENTER	BEREA
518110	BLUE GRASS HEMATOLOGY ONCOLOGY	LEXINGTON
518098	BLUEGRASS CANCER CENTER	FRANKFORT
518026	BLUEGRASS RADIATION ONCOLOGY	CAMPBELLSVILLE

518097	BOWLING GREEN RX ONC ASSOC	BOWLING GREEN
518067	BRANDENBURG PC	BRANDENBURG
518029	CANCER & BLOOD SPECIALISTS	LOUISVILLE
518044	CENTER FOR SURGICAL CARE	FORT THOMAS
518031	CINCINNATI HEM/ONC	CRESTVIEW HILLS
518052	COLORECTAL SURGICAL & GI ASSOC	LEXINGTON
518109	COMMONWEALTH HEMATOLOGY/ONCOL	FRANKFORT
518127	CONSULTANTS IN BLOOD DISORDERS	LOUISVILLE
518114	CRONIN'S CANCER CTR AT LEX CL	LEXINGTON
518053	CUMBERLAND VALLEY SURGERY CTR	CORBIN
518099	DANVILLE RADIATION TX CENTER	DANVILLE
518043	DIAGNOSTIC IMAGING	SHELBYVILLE
518119	DR CATHERINE HELTSLEY	BOWLING GREEN
518129	DR VISA	LONDON
518028	DUPONT MEDICAL IMAGING-NORTON	LOUISVILLE
518021	E. C. GREEN CANCER CENTER	HOPKINSVILLE
518121	EAST TN ONCOLOGY HEMATOLOGY	MIDDLESBORO
518122	E-TOWN ONCOLOGY HEMATOLOGY	ELIZABETHTOWN
518042	FAMILY HLTH CARE CENTER	SCOTTSVILLE
518043	GARDENVIEW WOMENS HLTH SERV	MANCHESTER
518018	GEORGETOWN CANCER TREATMENT CT	GEORGETOWN
518100	GLASGOW RX TX CENTER	GLASGOW
518101	GRAVES GILBERT CLINIC	BOWLING GREEN
518025	HEMATOLOGY & ONCOLOGY CENTER	SOMERSET
518047	HENDERSON CANCER CENTER	HENDERSON
518019	HIGHLANDS CANCER CENTER	PRESTONBURG
518126	JAMES GOULD, MD	PADUCAH
518001	JAMES GRAHAM BROWN CANCER CNTR	LOUISVILLE
518102	JAMES GRAHAM BROWN CLIN/DENTAL	LOUISVILLE
518040	JEWISH CANCER CARE	LOUISVILLE
518023	KENTUCKIANA CANCER INSTITUTE	LOUISVILLE
518104	KENTUCKY CANCER CLINIC	HAZARD
518030	KENTUCKY RAD THERAPY ASSOC	BOWLING GREEN
518103	KINDRED RADIATION CENTER	LOUISVILLE
518056	KNOX FAMILY MEDICINE	BARBOURVILLE

518039	KOSAIR CHILDREN'S MED CENTER	LOUISVILLE
518055	KY DIAGNOSTIC CENTER	EDGEWOOD
518017	LAKE CUMBERLAND AMB SG CENTER	SOMERSET
518057	LEATHERWOOD/BLACKEY MED CTR	CORNETTSVILLE
518058	LEWIS COUNTY PCC	VANCEBURG
518061	LEXINGTON CLINIC	LEXINGTON
518059	LEXINGTON DIAGNOSTIC CENTER	LEXINGTON
518111	LEXINGTON ONCOLOGY ASSOCIATES	LEXINGTON
518060	LEXINGTON SURGERY CENTER	LEXINGTON
518062	LEXINGTON/FAYETTE HEALTH DEPT	LEXINGTON
518130	LOUISVILLE ONCOLOGY(HISTORIC)	LOUISVILLE
518107	LOUISVILLE RADIATION ONCOLOGY	LOUISVILLE
518063	LOUISVILLE SURGERY CENTER	LOUISVILLE
518123	M AZEEM NIAZI, MD	MANCHESTER
518064	MAGNETIC RESONANCE IMAGING	LOUISVILLE
518065	MARTIN COUNTY RADIOLOGY	INEZ
518112	MAYSVILLE CANCER TREATMENT CTR	MAYSVILLE
518066	MCROBERTS MED CLINIC RHC	MCROBERTS
518068	MEDICAL ASSESSMENT CLINIC	LOUISVILLE
518069	MEDICAL HEIGHTS SURG CENTER	LEXINGTON
518070	MENIFEE MEDICAL CENTER	FRENCHBURG
518020	MONTGOMERY CANCER CENTER	MOUNT STERLING
518016	MOREHEAD CANCER TREATMENT CTR	MOREHEAD
518071	MOREHEAD CLINIC	MOREHEAD
518072	MRI ASSOCIATES	LEXINGTON
518022	MT STERLING CANCER TRTMENT CTR	MOUNT STERLING
518073	MUD CREEK CLINIC	GRETHEL
518037	NCI AUDUBON	LOUISVILLE
518046	NCI BARDSTOWN	BARDSTON
518049	NCI CLARKSVILLE	CLARKSVILLE
518034	NCI CORYDON	CORYDON
518033	NCI JEFFERSONVILLE	JEFFERSONVILLE
518045	NCI LAGRANGE	LAGRANGE
518036	NCI OBC	LOUISVILLE
518032	NCI PAVILLION	LOUISVILLE

518048	NCI RADIATION CENTER NORTHEAST	LOUISVILLE
518035	NCI SHELBYVILLE	SHELBYVILLE
518038	NCI SUBURBAN	LOUISVILLE
518074	NEWBURG PRIMARY CARE CENTER	LOUISVILLE
518024	NORTON BROWNSBORO HOSPITAL	LOUISVILLE
518106	ONCOLOGY HEMATOLOGY CARE	CRESTVIEW HILLS
518075	OWENSBORO AMBULATORY SURG	OWENSBORO
518041	OWSLEY BROWN FRAZIER RADIATION	LOUISVILLE
518076	OWSLEY CO MEDICAL CLINIC	BOONEVILLE
518078	PADUCAH AREA PHYSICIANS	PADUCAH
518077	PADUCAH MRI	PADUCAH
518079	PARK DUVALLE COMM HLTH CTR	LOUISVILLE
518080	PARKWAY MEDICAL CLINIC	MANCHESTER
518081	PINE MOUNTAIN CLINIC	BLEDSOE
518027	PREMIER DIAGNOSTICS-NORTON	LOUISVILLE
518137	RADIATION CENTERS OF KY	LOUISVILLE
518082	RED BIRD MOUNTAIN MED CTR	BEVERLY
518113	RICHMOND REGIONAL ONCOLOGY CTR	RICHMOND
518083	SALYERSVILLE HEALTH CARE CTR	SALYERSVILLE
518084	SOMERSET SURGERY CENTER	SOMERSET
518086	SOUTHEASTERN KY. DIAGNOSTIC	CORBIN
518085	SOUTHEASTERN KY RX ONCOLOGY	CORBIN
518015	SOUTHERN KY HEMATOLOGY & ONC	SOMERSET
518087	SPENCER COUNTY RHC	TAYLORSVILLE
518054	ST ELIZABETH IMAGING CENTERS	EDGEWOOD
518088	ST JOHNS HEALTH CLINIC	LOUISVILLE
518089	SURGECENTER OF LOUISVILLE	LOUISVILLE
518090	SURGICAL CTR OF ELIZABETHTOWN	ELIZABETHTOWN
518115	SURGICARE CENTER	PADUCAH
518092	THE EYE SURG CTR OF PADUCAH	PADUCAH
518091	THE MCPEAK SURGERY CENTER	GLASGOW
518094	TRI STATE REGIONAL CANCER CTR	ASHLAND
518105	U OF L PC CLINICS	LOUISVILLE
518005	UK CLINICS-BREAST	LEXINGTON
518003	UK CLINICS-DERMATOLOGY	LEXINGTON

518013	UK CLINICS-ENT	LEXINGTON
518004	UK CLINICS-GYNECOLOGY\ONCOLOGY	LEXINGTON
518009	UK CLINICS-INTERNAL MEDICINE	LEXINGTON
518012	UK CLINICS-KY CLINICS	LEXINGTON
518010	UK CLINICS-KY CLINIC SOUTH	LEXINGTON
518014	UK CLINICS-OPHTHALMOLOGY	LEXINGTON
518008	UK CLINICS-PEDIATRICS	LEXINGTON
518011	UK CLINICS-PLASTICS	LEXINGTON
518007	UK CLINICS-SURGERY	LEXINGTON
518006	UK CLINICS-UROLOGY	LEXINGTON
518002	UNITED RADIATION ONCOLOGY	LEXINGTON
518118	UNIVERSITY OB-GYN	LOUISVILLE
518124	VINAY VERMANI, MD	ASHLAND
518125	WESTERN KY HEMATOLOGY/ONC GRP	PADUCAH
518095	WOOTON RURAL HEALTH CLINIC	WOOTON

FREESTANDING PATHOLOGY LABORATORIES

Code	Name	City
517022	AMERIPATH KENTUCKY	LEXINGTON
517003	ASSOCIATED PATHOLOGY LABS	LEXINGTON
517005	CLINICAL PATH ASSOC	LOUISVILLE
517006	CORBIN PATHOLOGY	CORBIN
517007	CUMBERLAND MEDICAL LABS	SOMERSET
517008	DERMATOLOGISTS	STATEWIDE
517012	FIRST UROLOGY	JEFFERSONVILLE
517013	KY CABINET FOR HUM RES LABS	FRANKFORT
517018	LABCORP, INC.	LOUISVILLE
517032	LABORATORY PHYSICIANS	LOUISVILLE
517014	LABORATORY PHYSICIANS, PSC	LOUISVILLE
517033	LEXINGTON CLINIC PATH LAB	LEXINGTON
517015	LOUISVILLE JEFF CO PUBLIC HLTH	LOUISVILLE
517016	MEDICAL LAB OF HOPKINSVILLE	HOPKINSVILLE
517017	MEDICAL LAB SERVICES	OWENSBORO
517009	MEDICAL LABORATORY CONSULTANTS	LOUISVILLE
517010	NORTON CLINICAL PATH ASSOC	LOUISVILLE
517019	OFFICE PARK DX SERVICES	LEXINGTON

517031	OUT OF STATE LABS	OUTSIDE KY
517020	OWENSBORO MED CTR LAB	OWENSBORO
517021	P&C LABS	LEXINGTON
517023	PATHOLOGY LAB	ERLANGER
517001	QUEST DIAGNOSTICS	LEXINGTON
517024	ROCHE BIOMEDICAL LAB	PADUCAH
517025	ROCHE BIOMEDICAL LAB	LEXINGTON
517026	ROCHE BIOMEDICAL LAB	GLASGOW
517027	SOUTHERN MEDICAL LAB	GLASGOW
517028	TOTAL CARE	PINEVILLE
517029	TROVER CLINIC	MADISONVILLE
517004	U OF L ORAL PATH LAB	LOUISVILLE
517002	UK ORAL PATHOLOGY	LEXINGTON
517030	WL MILL PSC CLINICAL LAB	GREENVILLE

APPENDIX G - SURGICAL PROCEDURE CODES-FORDS

The site-specific surgery codes are taken from Appendix C of the 2010 SEER Program Coding and Staging Manual, which is based on Appendix B of the ACoS FORDS Manual - revised 2011. The surgery codes are identical to FORDS but the SEER appendix also contains supplementary annotations, including the 2007 MP/H rules and Collaborative Staging coding instructions. It can be found at:

http://seer.cancer.gov/manuals/2010/appendixc.html

To download the 2011 FORDS Manual, go to: http://www.facs.org/cancer/coc/fordsmanual.html.

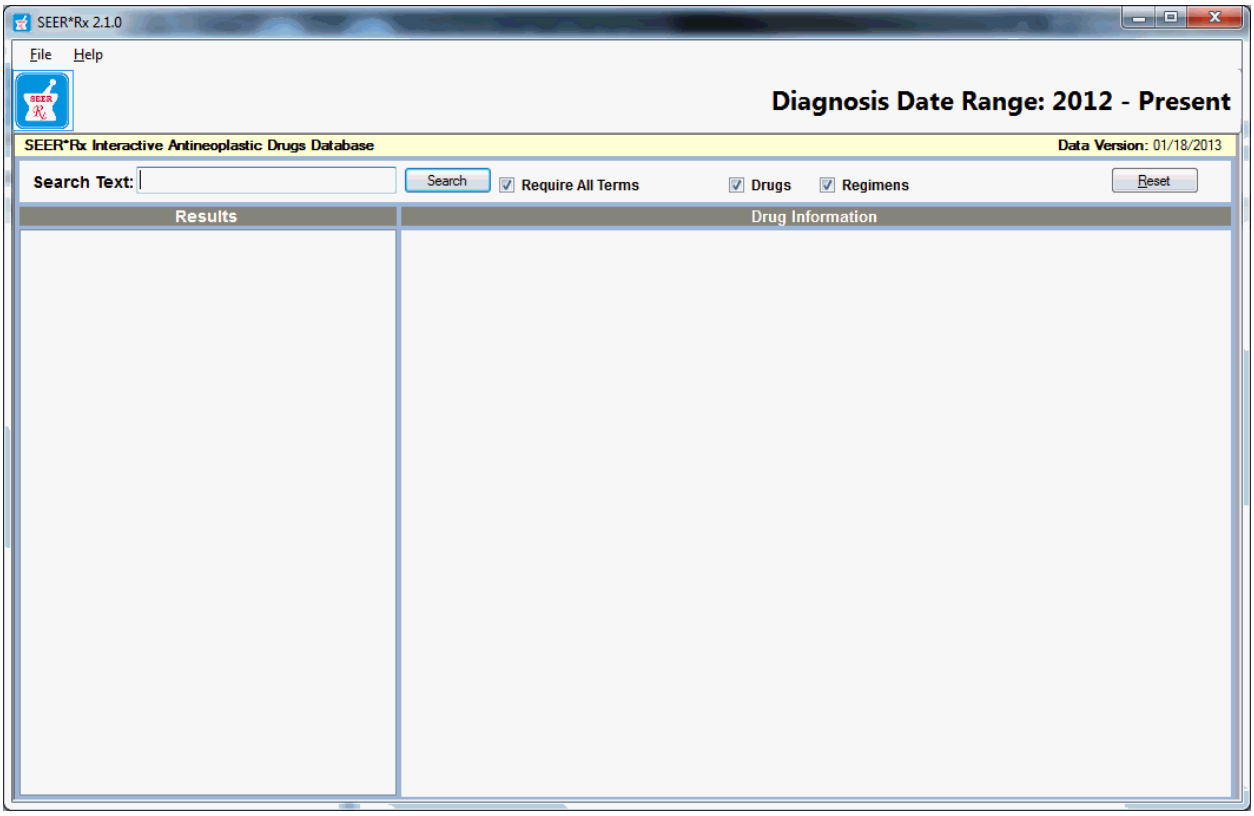
For diagnoses prior to January 1, 2003, use the ROADS surgery codes, which can be found at:

http://seer.cancer.gov/manuals/AppendC.pdf

APPENDIX H - TREATMENT AGENTS

For cases diagnosed from 2005 onward, the SEER Rx software should be used to identify and categorize treatment agents as chemotherapy, hormone agents, immunotherapy or ancillary agents. (Ancillary agents are not considered treatment.) The software is available from the SEER web page: http://seer.cancer.gov/tools/seerrx/

It looks like this:



The rest of Appendix H is to be used for diagnoses made prior to 2005.

THERAPY AGENTS (PRE-2005)

(Alphabetical Listing)

Helpful Information

*Different names for the same agent are separated by commas (,) within a line.

*Individual agents in combo regimens are separated by forward slashes (/).

*Some combo regimens consist of chemotherapy and hormone therapy agents (C, H); both categories should be entered as therapies.

*****When looking up a combo regimen by the individual agents, begin searching for the agent that comes
alphabetically first.
If it is not listed under that agent begin searching for the agent that comes alphabetically next, etc.
Remember that agents listed as a part of a combo regimen may be known by different names (synonyms).

Therapy Type

I biological response modifiers, otherwise known as immunotherapy
C chemotherapy agents
H hormone therapy agents

TYPE	AGENT CROSS-REFERENCE
C	2-FAS, 2-Fluroadenosine
C	2-Fluroadenosine, 2-FAS
C	5-Azacytidine, Azacytidine, AZA
C, H	5-azacytidine/Ara-C/Daunomycin/Prednisone/Vincristine, D-AZPO
C	5-Fluorouracil/Adriamycin/Cytoxan, CAF
C	5-fluorouracil/Andriamycin/Cytoxan/Methotrexate, CAMF
C	5-Fluorouridine, F3TDR
C	5-Fluoruracil, Adrucil, 5-FU
C	5-FU, Adrucil, 5-Fluoruracil
C	5-FU/Adriamycin/Cytoxan, FAC
C	5-FU/Adriamycin/Mitomycin C, FAM
C	5-FU/Adriamycin/Platinol, FAP
C	5-FU/BCNU/Dacarbazine/Vincristine, FIVB
C	5-FU/Cytoxan/Hexamethylmelamine/Methotrexate, HEXA-CAF
C	5-FU/Cytoxan/Methotrexate, CMF
C, H	5-FU/Cytoxan/Methotrexate/Prednisone, FACP
C, H	5-FU/Cytoxan/Methotrexate/Prednisone/Vincristine, COMFP
C	5-FU/Mitomycin C, MF
C	5-FU/Mitomycin C/Streptozotocin, SMF
C	5-FU/Mitomycin C/Vincristine, FOMi
C	5-FU/Mitomycin C/Vindesine, FEMi
C	5-FU/Mitomycin/Oncovin, MOF
C	5-FU/Mitomycin/Oncovin/Streptozotocin, MOF-S
C	6-Mercaptopurine riboside, 6MP
C, H	6-Mercaptopurine/Amethopterin/Prednisone/Vincristine, VAMP
C, H	6-mercaptopurine/L-Asparaginase/Methotrexate/Prednisolone/Vincristine, POMPA

C, H	6-Mercaptopurine/Methotrexate/Prednisone/Vincristine, POMP
C	6-Methylmercaptopurine riboside, 6-MMPR
C	6-MMPR, 6-Methylmercaptopurine riboside
C	6MP, 6-Mercaptopurine riboside
C	6TG, Thioguanine
C	6-Thioguanine/Ara-C/Daunomycin, TAD
I	13-CIS retinoic acid
C	A3, Chromomycin
C	AB-121, Meturedepa, TURLOC
C	ABVD, Adriamycin/Bleomycin/DTIC/Velban
C	AC, Adriamycin/Cytoxan, cyclophosphamide
C	ACDA, Anthracenedicarboxaldehyde, Orange crush , Bisantrene
C	ACE, Adriamycin/Cytoxan/VP-16, etoposide
C	Acivicin, AT-125
C	Acla A, adarubicin, Aclacinomycin A
C	Aclacinomycin A, adarubicin, Acla A
C	Acridinyl Anisidide, amsacrine, AMSA
C	ACTD, Cosmegan, Actinomycin D, Dactinomycin
H	ACTH, Adrenocorticotropin, Corticotropin
C	Actinomycin D, Dactinomycin, Cosmegan, ACTD
C	Actinomycin D/Chlorambucil/Methotrexate, MAC
C	Actinomycin D/DTIC/Vindesine, VAD
C	AD-32, Adriamycin derivative
C	Adarubicin, Aclacinomycin A, Acla A
C	ADCA,Orange Crush, Bisantrene
C, H	ADOAP, Adriamycin/Ara-C/Prednisone/Vincristine
C	ADR, Adriamycin, Doxorubicin
H	Adrenocorticotropin, Corticotropin, ACTH
C	Adriamycin derivative, AD-32
C	Adriamycin, Doxorubicin, ADR
C, H	Adriamycin/Ara-C/Prednisone/Vincristine, ADOAP
C, H	Adriamycin/BCNU/Prednisone/Vincristine, VBAP
C, H	Adriamycin/BCNU/Prednisone/Vindesine, EBAP
C	Adriamycin/Bleomycin/CCNU/Velban, BCAV
C	Adriamycin/Bleomycin/DTIC/Velban, ABVD
C	Adriamycin/Bleomycin/Platinol/Velban, PVBA
C	Adriamycin/CCNU/Cytoxan/Vincristine, CCV-AV
C	Adriamycin/CCNU/CytoxanMethotrexate, MACC
C	Adriamycin/CCNU/Methotrexate/Mitomycin C, MACM
C	Adriamycin/CIS-platinum/Cytoxan, CAP
C	Adriamycin/CIS-platinum/Cytoxan, PLAC

C	Adriamycin/CIS-platinum/Cytoxan/Hexamethylmelamine, CHAP
C	Adriamycin/Cyclophosphamide/Methotrexate/Procarbazine, CAMP
C	Adriamycin/Cytoxan, AC, cyclophosphamide
C	Adriamycin/Cytoxan, CA
C, H	Adriamycin/Cytoxan/BCNU/Prednisone, BCAP
C, H	Adriamycin/Cytoxan/Bleomycin/Oncovin/Prednisone, BACOP
C	Adriamycin/Cytoxan/DTIC/Vincristine, CYVADIC
C, H	Adriamycin/Cytoxan/Epipodophyllotoxin/Methotrexate/Prednisone, PRO-MACE
C	Adriamycin/Cytoxan/Hexamethylmelamine, CAH
C	Adriamycin/Cytoxan/Methotrexate, CAM
C	Adriamycin/Cytoxan/Platinol, PAC-5
C, H	Adriamycin/Cytoxan/Prednisone/Procarbazine/Vincristine, CHOPP
C, H	Adriamycin/Cytoxan/Prednisone/Vincristine, CHOP
C, H	Adriamycin/Cytoxan/Prednisone/Vincristine, VCAP
C, H	Adriamycin/Cytoxan/Tamoxifen, TAC
C, H	Adriamycin/Cytoxan/Tamoxifen/Vincristine, TACO
C	Adriamycin/Cytoxan/Vincristine, CAV
C	Adriamycin/Cytoxan/Vincristine, VAC
C	Adriamycin/Cytoxan/Vincristine/VP-16, CAVV
C	Adriamycin/Cytoxan/Vincristine/VP-16, EVAC
C	Adriamycin/Cytoxan/VP-16, ACE, etoposide
C	Adriamycin/Mitomycin C, MA
C	Adriamycin/Platinol, PA
C	Adriamycin/Procarbazine/Vindesine, VAP
C	Adriamycin/Vincristine, AV
C	Adrucil, 5-Fluoruracil, 5-FU
C	Alanosine
I	Aldara, Imiquinod
I	Aldesleukin, Proleukin
I	Alemtuzumab, Campath
C	Alimta
C	Alkeran, Melphalan, L-PAM, L-Phenylalanine Mustard, Phenylalamine Mustard
C, H	Alkeran/Prednisone, AP
C	Altretamine, Hexalen
C	Amethopterin, Methotrexate, MTX
H	Aminoglutethimide, Cytodren, Elipten
C	Aminopterin, APGA
C	Aminothiadiazole, ATDA
H	Amnestrogen
C	Amonofide, nafidimide, Ara A
C	AMSA, Acridinyl anisidide, Amsacrine

C	AMSA/CIS-platinum/Vindesine, APPLE
C	Amsacrine, Acridinyl anisidide, AMSA
H	Anastrozole, Arimidex
C	Anguidine
C	Aniline Mustard
C	Anthracenedicarboxaldehyde, ACDA, Orange crush, Bisantrene
C, H	AP, Alkeran/Prednisone
C	APGA, Aminopterin
C	APPLE, AMSA/CIS-platinum/Vindesine
C	Ara A, nafidimide, Amonofide
C	Ara-C, Cytarabine, Cytosar, Cytosine Arabinoside, Cytoclne Arabinoside
C	Ara-C/Daunorubicin, DA
C	Ara-C/DNR, Cytosar/Daunorubicin
C, H	Ara-C/PrednisoneRubidazone/Vincristine, ROAP
C	Ara-C/TG, Cytosar/Thioguanine
H	Arimidex, Anastrozole
H	Aromasin, Exemestane
C	Arsenic trioxide, Trisenox
C	Asparaginase
C	AT-125, Acivicin
C	Atabrine, Quinacrine, QUIN
C	ATDA, Aminothiadiazole
C	AV, Adriamycin/Vincristine
C	AZA, 5-Azacytidine, Azacytidine
C	Azacytidine, 5-Azacytidine, AZA
C	AZAG, Azaguanine
C	Azaguanine, AZAG
C	AZAS, Azaserine
C	Azaserine, AZAS
C	AZAT, Azathioprine
C	Azathioprine, AZAT
C	Azauracil, AZU
C	Azauridine, AZUR
C	Aziridinylbenzoquinone, AZQ
C	AZOT, Azotomycin
C	Azotomycin, AZOT
C	AZQ, Aziridinylbenzoquinone
C	AZU, Azauracil
C	AZUR, Azauridine
I	Bacillus of Calmette-Connaught, BCG-Connaught
I	Bacillus of Calmette-Guerin, BCG

I	Bacillus of Calmette-Pasteur, BCG-Pasteur
I	Bacillus of Calmette-Tice, BCG-Tice
C, H	BACOP, Adriamycin/Cytoxan/Bleomycin/Oncovin/Prednisone
C	BAF, Triazinate, Baker's Antifol
C	Baker's Antifol, Triazinate, BAF
C	Bayer 305, Moryanly, Sodium Suramin
C, H	BCAP, Adriamycin/Cytoxan/BCNU/Prednisone
C	BCAV, Adriamycin/Bleomycin/CCNU/Velban
I	BCG, Bacillus of Calmette-Guerin
I	BCG-Connaught, Bacillus of Calmette-Connaught
I	BCG-Pasteur, Bacillus of Calmette-Pasteur
I	BCG-Tice, Bacillus of Calmette-Tice
C	BCM, Mannomustine
C	BCMF, Bleomycin/Cytoxan/Fluorouracil/Methotrexate
C	BCNU, Carmustine
C	BCNU/Bleomycin/Hexamethylmelamine/Velban, HEXA-BVB
C	BCNU/Cytoxan/Methotrexate/MGBG/Vincristine, BCOMM
C, H	BCNU/Cytoxan/Oncovin/Prednisone, BCOP
C, H	BCNU/Cytoxan/Prednisone/Procarbazine/Vincristine, BVCPP
C	BCNU/DTIC/Hydroxyurea, BHD
C	BCNU/DTIC/Vincristine, BVD
C, H	BCNU/Prednisone/Procarbazine/Vincristine, BOPP
C	BCOMM, BCNU/Cytoxan/Methotrexate/MGBG/Vincristine
C, H	BCOP, BCNU/Cytoxan/Oncovin/Prednisone
C, H	BCP, Cytoxan/BCNU/Prednisone
C	BDCA, Diammine platinum, Carboplatin, CBDCA
H	Betamethasone, Celestone
C	Beta-TGdR, BTGR
I	Bexarotene, Targretin, LGD 1069
C	BHD, BCNU/DTIC/Hydroxyurea
H	Bicalutamide, Casodex
C	Bisantrene, Orange crush, Anthracenedicarboxaldehyde, ACDA
C	Blenoxane, Bleomycin. BLEO
C	BLEO, Blenoxane, Bleomycin
C	Bleomycin, Blenoxane, BLEO
C	Bleomycin/CIS-platinum/Velban, CVB
C	Bleomycin/Cytoxan/Fluorouracil/Methotrexate, BCMF
C	Bleomycin/Metomycin C, BM
C	Bleomycin/Mitomycin C/Vincristine, MOB
C	Bleomycin/Platinol/Velban, PVB
C	BM, Bleomycin/Metomycin C

I	Bone Marrow Transplant
C, H	BOPP, BCNU/Prednisone/Procarbazine/Vincristine
I	Bromocriptine
C	Bromodeoxyuridine, BUDR
C	Bruceantin
C	BTGR, Beta-TGdR
C	BUDR, Bromodeoxyuridine
C	BUS, Busulfan, Myleran
C	Busulfan, Myleran, BUS
C	Butanoic Acid, Indicine-N-oxide
C	Butocin
C, H	BVCPP, BCNU/Cytoxan/Prednisone/Procarbazine/Vincristine
C	BVD, BCNU/DTIC/Vincristine
C	CA, Adriamycin/Cytoxan
C	CAF, 5-Fluorouracil/Adriamycin/Cytoxan
C	CAH, Adriamycin/Cytoxan/Hexamethylmelamine
H	CAL, Calusterone, Methosarb
H	Calusterone, Methosarb, CAL
C	CAM, Adriamycin/Cytoxan/Methotrexate
C	CAMF, 5-fluorouracil/Andriamycin/Cytoxan/Methotrexate
C	CAMP, Adriamycin/Cyclophosphamide/Methotrexate/Procarbazine
I	Campath, Alemtuzumab
C	Camptosar, Irinotecan
C	Camptothecin
C	CAP, Adriamycin/CIS-platinum/Cytoxan
C	Capecitabine, Xeloda
C	Caracemide
H	Carbestrol
C	Carboplatin, Diammine platinum, BDCA, CBDCA
C	Carmustine with Prolifeprosan 20 Implant, Gliadel Wafer
C	Carmustine, BCNU
H	Casodex, Bicalutamide
C	CAV, Adriamycin/Cytoxan/Vincristine
C	CAVV, Adriamycin/Cytoxan/Vincristine/VP-16
C	CBDCA, Carboplatin, Diammine platinum, BDCA
C	CCNU, Lomustine
C	CCNU/Cytoxan/Procarbazine/Vincristine, POCC
C	CCNU/Cytoxan/Vincristine, CCV
C	CCNU/Procarbazine/Vincristine, PCV
C, H	CCSG, L-asparaginase/Prednisone/Vincristine
C	CCV, CCNU/Cytoxan/Vincristine

C	CCV-AV, Adriamycin/CCNU/Cytoxan/Vincristine
C	C-DDP, Platinol, CIS-platinum, cisplatin
H	Celestone, Betamethasone
C	CHAP, Adriamycin/CIS-platinum/Cytoxan/Hexamethylmelamine
C	CHIP
C	CHL, Chlorambucil, Leukeran
C	Chlorambucil, Leukeran, CHL
H	Chlormadinone acitate
H	Chlorotrinanisene, TACE
C	Chlorozotocin, DCNU
C, H	CHOP, Adriamycin/Cytoxan/Prednisone/Vincristine
C, H	CHOPP, Adriamycin/Cytoxan/Prednisone/Procarbazine/Vincristine
C	Chromomycin, A3
C	Cisplatin, Platinol, C-DDP, CIS-Platinum
C	CIS-platinum, Platinol, C-DDP, cisplatin
C	Cladrabine, Leustatin
C	CMC, Cytoxan/Lomustine/Methotrexate
C	CMF, 5-FU/Cytoxan/Methotrexate
C, H	CMFVP, Cytoxan/Fluorouracil/Methotrexate/Prednisone/Vincristine
C, H	C-MOPP, Cytoxan/Methotrexate/Oncovin/Prednisone/Procanbazine
C, H	COAP, Cytosine arabinoside/Cytoxan/Prednisone/Vincristine
C	Colchicine
C	COM, Cytoxan/Methotrexate/Vincristine
C, H	COMFP, 5-FU/Cytoxan/Methotrexate/Prednisone/Vincristine
C, H	COMP, Cytoxan/Methotrexate/Prednisone/Vincristine
H	Compound E, Cortisone acetate
H	Conjugated Estrogens
C, H	COP, Cytoxan/Prednisone/Vincristine
I	Coparvax, C-Parvum, Corynebacterium Parvum, CPAR
H	Corticotropin, ACTH, Adrenocorticotropin
H	Cortisone acetate, Compound E
I	Corynebacterium Parvum, C-Parvum, Coparvax, CPAR
C	Cosmegan, Actinomycin D, Dactinomycin, ACTD
I	Coumarin
I	CPAR, C-Parvum, Corynebacterium Parvum, Coparvax
I	C-Parvum, Corynebacterium Parvum, Coparvax CPAR
C	CPT-11
C	CTB, Cytembena
C	CTX, Neosar, Cyclophosphamide, Cytoxine, Cytoxan
C	CVB, Bleomycin/CIS-platinum/Velban
C	Cyclo-C, Cyclocytidine

C	Cyclocytidine, Cyclo-C
C	Cyclo-L, Cycloleucine
C	Cycloleucine, Cyclo-L
C	Cyclophosphamide, AC, Adriamycin/Cytoxan
C	Cyclophosphamide, Cytoxine, Neosar, CTX, Cytoxan
H	Cyproterone acetate
C	Cytarabine liposomal, Depocyt
C	Cytarabine, Cytosar, Cytosine Arabinoside, Ara-C
C	Cytembena, CTB
C	Cytoclne Arabinoside, Cytosine Arabinoside, Ara-C, Cytosar, Cytarabine
H	Cytodren, Elipten, Aminoglutethimide
C	Cytosar, Cytosine Arabinoside, Cytoclne Arabinoside, Cytarabine, Ara-C
C	Cytosar/Daunorubicin, Ara-C/DNR
C	Cytosar/Thioguanine, Ara-C/TG
C	Cytosine Arabinoside, Cytoclne Arabinoside, Cytosar, Cytarabine, Ara-C
C, H	Cytosine arabinoside/Cytoxan/Prednisone/Vincristine, COAP
C	Cytoxan, Cyclophosphamide, CTX, Neosar, Cytoxine
C, H	Cytoxan/BCNU/Prednisone, BCP
C, H	Cytoxan/Fluorouracil/Methotrexate/Prednisone/Vincristine, CMFVP
C	Cytoxan/Lomustine/Methotrexate, CMC
C, H	Cytoxan/Methotrexate/Oncovin/Prednisone/Procanbazine, C-MOPP
C, H	Cytoxan/Methotrexate/Prednisone/Vincristine, COMP
C	Cytoxan/Methotrexate/Vincristine, COM
C, H	Cytoxan/Prednisone/Vincristine, COP
C	Cytoxine, Cyclophosphamide, Neosar, CTX, Cytoxan
C	CYVADIC, Adriamycin/Cytoxan/DTIC/Vincristine
C	DA, Ara-C/Daunorubicin
C	Dacarbazine, DTIC
C	Dactinomycin, Actinomycin D, Cosmegan, ACTD
C	DAG, Dianhydrogaloctitol
H	Danazol
C, H	Daraprim/Dexamethasone/Oncovin/Thioquanine, TODD
C	Daunomycin, Daunorubicin, DNR
C	Daunorubicin liposomal, Daunoxome
C	Daunorubicin, Daunomycin, DNR
C	Daunoxome, Daunorubicin liposomal
C, H	D-AZPO, 5-azacytidine/Ara-C/Daunomycin/Prednisone/Vincristine
C	DBD, Dibromodulcitol
C	DBM, Dibromolannitol
C	DCM, Dichloromethotrexate
C	DCNU, Chlorozotocin

C DDMP, Meteprine
C Deazauridine
H DECA*, Dexamethasone*, Decadron*
H Decadron*, DECA*, Dexamethasone*
I Denileukin diftitox, Ontak
C Deoxycoformycin, Nipent, Pentostatin
C Deoxydoxorubincin
C Deoxyspergualin
H Depo Provera, Medroxyprogesterone Acetate
C Depocyt, Cytarabine liposomal
H DES, Diethylstilbestrol, Stilbesterol
C Desmethylmisonidozole
H Dexamethasone*, Decadron*, DECA*
C DHAD, Mitoxantrone, Dihydroxyanthracenedione
H DHEA Mustard, DHEA
H DHEA, DHEA Mustard
C Diammine platinum, Carboplatin, BDCA, CBDCA
C Dianhydrogaloctitol, DAG
C Dibromodulcitol, DBD
C Dibromolannitol, DBM
C Dichloromethotrexate, DCM
H Diethylstilbestrol, Stilbesterol, DES
C Diglycoaldehyde, STGdR
C Dihydro-5Azacytidine
C Dihydropenperone
C Dihydroxyanthracenedione, Mitoxantrone, DHAD
H Dimethisterone
C Dimethyl Sulfoxide, DMSO
C DMSO, Dimethyl Sulfoxide
I DNCB
C DNR, Daunomycin, Daunorubicin
C Docetaxel, Taxotere
C DON, Duazomycin
C Doxil, Doxorubicin liposomal
C Doxorubicin liposomal, Doxil
C Doxorubicin liposomal, Doxil
C Doxorubicin, Adriamycin, ADR
H Drolban, Dromostanolone propionate
H Dromostanolone propionate, Drolban
C DTIC, Dacarbazine
C Duazomycin, DON

C	DVA, Vindesine
C, H	EBAP, Adriamycin/BCNU/Prednisone/Vindesine
C	Echinomycin, Quinomycin A
H	Eligard, Leuprolide acetate
H	Elipten, Aminoglutethimide, Cytodren
C	Ellence, Epirubicin, Epi-Doxorubicin, EpI
C	Eloxatine, Oxaliplatin
C	Elspar, L-Asparaginase, L-ASP
H	Emcyt, Estramustine
C	EMET, Emetine HCl
C	Emetine HCl, EMET
C	EpI, Ellence, Epirubicin, Epi-Doxorubicin
C	Epi-Doxorubicin, Epirubicin, Ellence, EpI
C	Epirubicin, Epi-Doxorubicin, Ellence, EpI
I	Epratuzumab
H	Equilin
I	Ergamisol, Levamisole
H	Estradiol
H	Estramustine, Emcyt
H	Estriol
H	Estrone
C	Ethidium Chloride
H	Ethinyl estradiol
H	Ethisterone, Hydroxprogesterone
H	Ethynodiol Diacetate
C	Etopophos, Etoposide phosphate
C	Etoposide phosphate, Etopophos
C	etoposide, ACE, Adriamycin/Cytoxan/VP-16
C	Etoposide, VP-16-213, VP-16
H	Eulexin, Flutamide
C	EVAC, Adriamycin/Cytoxan/Vincristine/VP-16
H	Exemestane, Aromasin
C	F3TDR, 5-Fluorouridine
C	FAC, 5-FU/Adriamycin/Cytoxan
C, H	FACP, 5-FU/Cytoxan/Methotrexate/Prednisone
C	FAM, 5-FU/Adriamycin/Mitomycin C
C	FAP, 5-FU/Adriamycin/Platinol
H	Fareston, Toremifene
H	Faslodex, Fulvestrant
H	Femara, Letrozole
C	FEMi, 5-FU/Mitomycin C/Vindesine

C	FIVB, 5-FU/BCNU/Dacarbazine/Vincristine
C	Flavone Acetic Acid
C	Floxuridine, FUDR
C	Fludarabine Phosphate
C	Fluorouracil
H	Fluoxymesterone, Halotestin, HAL
H	Fluprednisolone
H	Flutamide, Eulexin
C	FOMi, 5-FU/Mitomycin C/Vincristine
C	FUDR, Floxuridine
H	Fulvestrant, Faslodex
C	GA(N03)3, Gallium Nitrate
C	Gallium Nitrate, GA(N03)3
C	Gefitinib, ZD1839, Iressa
C	Gemcitabine, Gemzar
C	Gemtuzumab-ozogamicin, Mylotarg
C	Gemzar, Gemcitabine
C	Gleevec, Imatinib mesylate
C	Gliadel Wafer, Carmustine with Prolifeprosan 20 Implant
C	Guanazole
H	HAL, Fluoxymesterone, Halotestin
H	Halotestin, HAL, Fluoxymesterone
I	Herceptin, Trastuzumab
C	HEXA-BVB, BCNU/Bleomycin/Hexamethylmelamine/Velban
C	HEXA-CAF, 5-FU/Cytoxan/Hexamethylmelamine/Methotrexate
C	Hexalen, altretamine
C	Hexamethylmelamine, HXM
C	Hexamethylmelamine/Methotrexate/VP-16, MVH
C	Hexamethylmelamine/Mitomycin C/Velban, HVM
H	Hexestrol
C	HMBA
H	HMD, Oxymetholone
C	HN2, Mustargen, Nitrogen Mustard, Mechlorethamine
C	HU, Hydrea, Hydroxyurea
C	HVM, Hexamethylmelamine/Mitomycin C/Velban
C	HXM, Hexamethylmelamine
C	Hycamtin, Topotecan
C	Hycanthone mesylate
C	Hydrea , Hydroxyurea, HU
H	Hydrocortisone*
H	Hydroxprogesterone, Ethisterone

C	Hydroxyurea, Hydrea, HU
C	Idamycin, Idarubicin
C	Idarubicin, idamycin
C	Idoxuridine, IDU
C	IDU, Idoxuridine
I	IF, Interferon, Interleukan 2
C	IFOS, Isophosphamide, Ifosfamide
C	Ifosfamide, Isophosphamide, IFOS
C	Imatinib mesylate, Gleevec
I	Imiquinod, Aldara
C	Indicine-N-Oxide, Butanoic Acid
I	Interferon Alpha 2a and 2b
I	Interferon, IF, Interleukan 2
I	Interleukan 2, IF, Interferon
C	Iressa, Gefitinib, ZD1839
C	Irinotecan, camptosar
C	Isophosphamide, Ifosfamide, IFOS
I	LAK cells
C	L-ASP, Elspar, L-Asparaginase
C	L-Asparaginase, Elspar, L-ASP
C, H	L-asparaginase/Prednisone/Vincristine, CCSG
C, H	L-asparaginase/Prednisone/Vincristine, VPL-ASP
C	LCR, Vincristine Sulfate, Leurocristine, Leurocristine Oncovin, Vincristine, Oncovin, VCR
H	Letrozole, Femara
C	Leukeran, Chlorambucil, CHL
H	Leuprolide acetate implant, Viadur
H	Leuprolide acetate, Eligard
H	Leuprolide, Lupron
C	Leurocristine Oncovin, Vincristine Sulfate, Vincristine, Oncovin, Leurocristine, VCR, LCR
C	Leurocristine, Vincristine Sulfate, Vincristine, Leurocristine Oncovin, Oncovin, VCR, LCR
C	Leustatin, Cladrabine
I	Levamisole, Ergamisol
H	Levothyroxine
I	LGD 1069, Bexarotene, Targretin
H	Liothyronine
H	Liotrix
C	Lomustine, CCNU
C	L-PAM, Melphalan, Alkeran, L-Phenylalanine Mustard, Phenylalamine Mustard

C	L-Phenylalanine Mustard, L-PAM, Melphalan, Alkeran, Phenylalamine Mustard
H	Lupron, Leuprolide
C	MA, Adriamycin/Mitomycin C
C	MAC, Actinomycin D/Chlorambucil/Methotrexate
C	MACC, Adriamycin/CCNU/CytoxanMethotrexate
C	MACE, Methotrexate/Adriamycin/CCNU/Cytoxan
C	MACM, Adriamycin/CCNU/Methotrexate/Mitomycin C
C	Mannomustine, BCM
C	Maytansine
C	MCCNU, Methyl-CCNU, Semustine
C	Mechlorethamine, Nitrogen Mustard, Mustargen, HN2
H	Medroxyprogesterone Acetate, Depo Provera
H	Megace, Megestrol Acetate
H	Megestrol Acetate, Megace
H	Melengestrol Acetate
C	Melphalan, Alkeran, L-PAM, L-Phenylalanine Mustard, Phenylalamine Mustard
C, H	Melphalan/Prednisone, MP
C	Melphalan/Procarbazine/Velban, PAVe
I	MER, Mer-BCG
C	Merbarone
I	Mer-BCG, MER
C	Mesna, Methyltetrahydrohomofolate
H	Mestranol
C	Meteprine, DDMP
H	Methandrostenolone
H	Methosarb, CAL, Calusterone
C	Methotrexate, Amethopterin, MTX
C	Methotrexate/Adriamycin/CCNU/Cytoxan, MACE
C, H	Methotrexate/Prednisone/Vincristine, VMP
C	Methoxsalen
C	Methyl-CCNU, Semustine, MCCNU
C	Methyl-GAG, Mitoguazone, MGBG
H	Methylprednisolone acetate*
H	Methylprednisolone sodium succinate*
H	Methylprednisolone*
H	Methylprogesterone
H	Methyltestosterone
C	Methyltetrahydrohomofolate, Mesna
C	Meturedepa, AB-121, TURLOC
C	Meturedepa, TURLOC, AB-121
C	MF, 5-FU/Mitomycin C

C	MGBG, Mitoguazone, Methyl-GAG
C	MIPE, Mitomycin C/Platinum/Vindesine
C	Misonidazole
C	MITH, Mithramycin
C	Mithracin, Plicamycin
C	Mithramycin, MITH
C	Mito C/Vindesine, MIVe
C	MITO-C, Mutomycin, Mitomycin-C
C	Mitoguazone, Methyl-GAG, MGBG
C	Mitomycin C/Platinum/Vindesine, MIPE
C	Mitomycin C/Velban, VM
C	Mitomycin-C, Mutomycin, MITO-C
C	Mitotane, O'p'-DDD
C	Mitoxantrone, Dihydroxyanthracenedione, DHAD
C	MIVe, Mito C/Vindesine
C	MOB, Bleomycin/Mitomycin C/Vincristine
C	MOF, 5-FU/Mitomycin/Oncovin
C	MOF-S, 5-FU/Mitomycin/Oncovin/Streptozotocin
I	Monoclonal antibody
C, H	MOPP, Nitrogen mustard/Prednisone/Procarbazine/Vincristine
C	Moryanly, Sodium Suramin, Bayer 305
C, H	MP, Melphalan/Prednisone
C	MTX, Methotrexate, Amethopterin
C	Mustargen, Nitrogen Mustard, Mechlorethamine, HN2
C	Mutomycin, Mitomycin-C, MITO-C
I	MVE 2, Pyran copolymer
C	MVH, Hexamethylmelamine/Methotrexate/VP-16
C	Myleran, Busulfan, BUS
C	Mylotarg, Gemtuzumab-ozogamicin
C	Nafidimide, Amonofide, Ara A
H	Nalfoxidine HCL, NFX
H	Nandrolone Decanoate
C	Navalbine, Vinorelbine tartrate
C	Neosar, Cyclophosphamide, Cytoxine, CTX, Cytoxan
H	NFX, Nalfoxidine HCL
H	Nilandron, Nilutamide
H	Nilutamide, Nilandron
C	Nipent, Pentostatin, Deoxycoformycin
C	Nitrogen Mustard, Mechlorethamine, Mustargen, HN2
C, H	Nitrogen mustard/Prednisone/Procarbazine/Vincristine, MOPP
C	N-Methylformamide

H	Norethindrone Acetate
H	Novaldex, TMX, Tamoxifen Citrate
I	Oncaspar, Pegasparagase
C	Oncovin, Vincristine, Leurocristine, Vincristine Sulfate, Leurocristine Oncovin, LCR, VCR
I	Ontak, Denileukin diftitox
C	O'p'-DDD, Mitotane
C	Orange crush, ACDA, Anthracenedicarboxaldehyde, Bisantrene
C	Oxaliplatin, Eloxatine
C	Oxandrolone
H	Oxiplatin
C	Oxymetholone, HMD
C	PA, Adriamycin/Platinol
C	PAC-5, Adriamycin/Cytoxan/Platinol
C	Paclitaxel, Paxene, Taxol
H	PALA
C	Paramethasone*
C	PAVe, Melphalan/Procarbazine/Velban
C	Paxene, Paclitaxel, Taxol
C	PCH, Procarbazine HCl
C	PCNU
C	PCV, CCNU/Procarbazine/Vincristine
H	PDA, Phosphorodiamidic Acid
I	PDN, Prednisone*
C	Pegasparagase, Oncaspar
C	Pentamethylmelamine, PMM
C	Pentostatin, Deoxycoformycin, Nipent
C	Phenylalamine Mustard, L-PAM, Melphalen, Alkeran, L-Phenylalamine Mustard
C	Phosphorodiamidic Acid, PDA
C	Photofrin
C	PIBR, Pipobroman
C	PIP, Piperazenedione
C	Piperazenedione, PIP
C	Pipobroman, PIBR
C	Piposulfan, PISU
C	PISU, Piposulfan
C	PLAC, Adriamycin/CIS-platinum/Cytoxan
C	Platinol, CIS-platinum, C-DDP, Cisplatin
C	Plicamycin, mithracin
C	PMM, Pentamethylmelamine
C	POCC, CCNU/Cytoxan/Procarbazine/Vincristine

C	Podophyllin. SPG
H	Poly-5-Iodocytidilic, Poly-lC
C	Polyestradiol Phosphate
C, H	Poly-lC, Poly-5-Iodocytidilic
C	POMP, 6-mercaptopurine/Methotrexate/Prednisone/Vincristine
C	POMPA, 6-Mercaptopurine/L-Asparaginase/Methotrexate/Prednisolone/Vincristine
C	PORF, Porfiromycin
H	Porfiromycin, PORF
C, H	Prednisone*, PDN
C	Prednisone/Vincristine, VP
H	Procarbazine HCL, PCH
I	Progesterone
C, H	Proleukin, Aldesleukin
C	PRO-MACE, Adriamycin/Cytoxan/Epipodophyllotoxin/Methotrexate/Prednisone
C	PVB, Bleomycin/Platinol/Velban
I	PVBA, Adriamycin/Bleomycin/Platinol/Velban
C	Pyran copolymer, MVE 2
C	Pyrazofurin
C	Pyrazole
C	QUIN, Atabrine, Quinacrine
C	Quinacrine, Atabrine, QUIN
C	Quinomycin A, Echinomycin
C	Raltitrexed, Tomudex
C	Riboxamide, Tiazofurin, TCAR
I	Rituxan, Rituximab
I	Rituximab, Rituxan
C, H	ROAP, Ara-C/PrednisoneRubidazone/Vincristine
C	RUB, Rubidazone
C	Rubidazone, RUB
I	Sandostatin, Octreotide (deleted in 2005 - considered ancillary drug)
C	Semustine, Methyl-CCNU, MCCNU
C	SMF, 5-FU/Mitomycin C/Streptozotocin
C	Sodium Suramin, Moryanly, Bayer 305
C	SPG, Podophyllin
C	Spiro-32, Spirogermanium
C	Spirogermanium, Spiro-32
C	Spiromustin
H	Spironolactone
C	SR-2508
H	Stanolone
H	Stanozolol

I	Stem cell transplant
C	STGdR, Diglycoaldehyde
H	Stilbesterol, DES, Diethylstilbestrol
C	Streptozotocin, STZ
C	STZ, Streptozotocin
H	Synthroid (for papillary and/or follicular cancers of the thyroid only)
C	TAC, Adriamycin/Cytoxan/Taxotere
H	TACE, Chlorotrinanisene
C, H	TACO, Adriamycin/Cytoxan/Tamoxifen/Vincristine
C	TAD, 6-Thioguanine/Ara-C/Daunomycin
H	Tamoxifen Citrate, Novaldex, TMX
C	Targretin, Bexarotene, LGD 1069
H	TATBA, Triamcinolone hexacetonide
C	Taxol, Paxene, Paclitaxel
C	Taxotere, Docetaxel
C	TCAR, Riboxamide, Tiazofurin
C	Temodar, Temozolamide, Temodol
C	Temodol, Temodar, Temozolamide
C	Temozolamide, Temodar, Temodol
C	Teniposide, VM-26
C	TEPA, Triethylene Phosphoramide
H	Teslac, TL, Testaolactone
H	Testaolactone, Teslac, TL
H	Testosterone Enanthate
H	Testosterone Propionate, TP
C	Tetrahydrouridine, THU
C	Thioguanine, 6TG
C	Thio-TEPA, Thiotepa, TSPA
C	Thiotepa, Thio-TEPA, TSPA
C	THU, Tetrahydrouridine
C	Thymidine
I	Thymosin
H	Thyroglobulin
H	Thyrotropin, TSH
C	Tiazofurin, Riboxamide, TCAR
H	TL, Testaolactone, Teslac
C	TMCA, Trimethylcolchilcinic acid
H	TMX, Tamoxifen Citrate, Novaldex
C, H	TODD, Daraprim/Dexamethasone/Oncovin/Thioquanine
C	Tomudex, Raltitrexed
C	Topotecan, Hycamtin

H	Toremifene, Fareston
H	TP, Testosterone Propionate
I	Trastuzumab, Herceptin
H	Trelstar Depot, Triptorelin pamoate
H	Triamcinolone
H	Triamcinolone hexacetonide, TATBA
C	Triapine
C	Triazinate, Baker's Antifol, BAF
C	Tricirloinephosphate
C	Triethylene Phosphoramide, TEPA
H	Triiodothyronine, TRIT
H	Trilostane
C	Trimethylcolchilcinic acid, TMCA
C	Trimetrexate
H	Triptorelin pamoate, Trelstar Depot
C	Trisenox, Arsenic trioxide
H	TRIT, Triiodothyronine
H	TSH, Thyrotropin
C	TSPA, Thio-TEPA, Thiotepa
C	Tubercidin
C	TURLOC, Meturedepa, AB-121
C	UR, Uracil
C	Uracil, UR
C	VAC, Adriamycin/Cytoxan/Vincristine
I	Vaccine therapy
C	VAD, Actinomycin D/DTIC/Vindesine
C	Valrubicin, Valstar
C	Valstar, Valrubicin
C, H	VAMP, 6-Mercaptopurine/Amethopterin/Prednisone/Vincristine
C	VAP, Adriamycin/Procarbazine/Vindesine
C, H	VBAP, Adriamycin/BCNU/Prednisone/Vincristine
C, H	VCAP, Adriamycin/Cytoxan/Prednisone/Vincristine
C	VCR, Leurocristine Oncovin, Vincristine Sulfate, Vincristine, Leurocristine, LCR, Oncovin
C	Velban, Vinblastine Sulfate, VLB
H	Viadur, Leuprolide acetate implant
C	Vinblastine Sulfate, Velban, VLB
C	Vincristine Sulfate, Leurocristine, Oncovin, Leurocristine Oncovin, Vincristine, LCR, VCR
C	Vincristine, Oncovin, Leurocristine Oncovin, Vincristine Sulfate, Leurocristine, VCR, LCR

C	Vindesine, DVA
C	Vinorelbine tartrate, navalbine
I	Virus therapy
I	VIT-A, Vitamin A
I	Vitamin A, VIT-A
C	VLB, Velban, Vinblastine Sulfate
C	VM, Mitomycin C/Velban
C	VM-26, Teniposide
C, H	VMP, Methotrexate/Prednisone/Vincristine
C	VP, Prednisone/Vincristine
C	VP-16, Etoposide, VP-16-213
C, H	VP-16-213, Etoposide, VP-16
C	VPL-ASP, L-asparaginase/Prednisone/Vincristine
C	WR-2721
C	Xeloda, Capecitabine
C	Yoshi-864
H	ZD1839, Iressa, Gefitinib
	Zoladex

APPENDIX I - COMMON ACCEPTABLE ABBREVIATIONS

Word	Abbreviation
Abdomen	ABD
Abdominal Perineal	AP
Acid Phosphatase	ACID PHOS
Acquired Immunodeficiency Syndrome	AIDS
Acute Lymphocytic Leukemia	ALL
Acute Myelogenous Leukemia	AML
Adenocarcinoma	ADENOCA
Additional	ADDTL
Adjacent	ADJ
Adrenal	ADR
Armed Forces Institute of Pathology	AFIP
Alcohol	ETOH
Alkaline Phosphatase	ALK PHOS
Alpha-fetoprotein	AFP
Ambulatory	AMB
Anaplastic	ANAP
Angiography	ANGIO
Anterior	ANT
Anteroposterior	AP
Appendix	APP
Approximatley	APPROX
Aspiration	ASP
Axilla(ry)	AX
Bacillus Calmette-Guerin	BCG
Barium	BA
Barium Enema	BE
Benign Prostatic Hypertrophy/Hyperplasia	BPH
Bilateral	BIL
Bilateral Salpingo-oophorectomy	BSO
Biological Response Modifier	BRM
Biopsy	BX
Blood Urea Nitrogen	BUN
Bone Marrow	BM
Bone Scan	BSC
Carcinoembryonic Antigen	CEA
Carcinoma	CA
Carcinoma In Situ	CIS
CAT Scan	CT, CT SC
Centimeter	CM

Central Nervous System	CNS
Cerebrospinal Fluid	CSF
Cervical Intraepithelial neoplasia	CIN
Cervical Vertebra	C1-C7
Cervix	CX
Cesium	CSF
Chemotherapy	CHEMO
Chest Xray	CXR
Chronic Lymphocytic Leukemia	CLL
Chronic Myeloid Leukemia	CML
Cigarettes	CIG
Clear	CLR
Colon:	
Ascending	A-COLON
Decending	D-COLON
Sigmoid	S-CLON
Transverse	T-COLON
Common Bile Duct	CBD
Computerized Axial Tomography Scan	CT,CAT SCAN
Consist with	C/W
Continue	CONT
Cystoscopy	CYSTO
Cytology	CYTO
Cytomegalovirus	CMV
Date of Birth	DOB
Dermatology	DERM
Diagnosis	DX
Diameter	DIAM
Differentiated	DIFF
Dilatation and Curettage	D&c
Discharge	DIS,DISCH,DS
Discontinued	DC
Disease	DZ, DIS
Doctor	DR, MD
Ears, Nose, and Throat	ENT
Endoscopic Retrograde Cholangiopancreatography	ERCP
Enlarged	ENL
Esophagogastroduodenoscopy	EGD
Estrogen Receptor (Assay)	ER(A)
Evaluation	EVAL
Examination	EXAM
Examination Under Anesthesia	EUA
Excision	EXC

Exploratory Laparotomy	EXP LAP
Extend	EXT
Extension	EXT
External	EXT
Eyes, Ears, Nose, and Throat	EENT
Floor of Mouth	FOM
Follow-up	FU
Fracture	FX
Frozen Section	FS
Gallbladder	GB
Gastroenterostomy	GE
Gastroesophageal	GE
Gastrointestinal	GI
Genitourinary	GU
Grade	GR
Gynecology	GYN
Head, Eyes, Ears, Nose, Throat	HEENT
Hepatosplenomegaly	HSM
Histology	HISTO
History	HX
History and Physical	H&P
History of	HO
history of Present Illness	HPI
Hormone	HORM
Hospital	HOSP
Human Chorionic Gonadotropin	HCG
Human Immunodeficiency Virus	HIV
Human Papilloma Virus	HPV
Human T-Lymphotrophic Virus Type III	HTLV-III
Hysterctomy	HYST
Immunoglobulin	IG
Impression	IMP
Includes, Including	INCL
Inferior Vena Cava	IVC
Infiltrating	INFILT
Information	INFO
Inpatient	IP
Intrathecal	IT
Intravaneous	IVC
Intraveneous Pyelogram	IVP
Kidneys, Ureters, Bladder	KUB
Laparotomy	LAP
Large	LG

Lateral	LAT
Left	L, LT
Left Lower Extremity	LLE
Left Lower Lobe	LLL
Left Lower Quadrant	LLQ
Left Salpingo-oophorectomy	LSO
Left Upper Extremity	LUE
Left Upper Lobe	LUL
Left Upper Quadrant	LUQ
Local M.D.	LMD
Lower Extremity	LE
Lower Inner Quadrant	LIQ
Lower Outer Quadrant	LOQ
Lumbar Puncture	LP
Lumbar Vertebra	L1-L5
Lumbosacral	LS
Lymphadenopathy	LAD/LAN
Lymphadenopathy-Associated Virus	LAV
Lymph Node(s)	LN, LN'S, LNS
Magnetic Resonance Imaging	MRI
Malignant	MALIG, MAL
mandible	MAND
Mastectomy	MAST
Maxilla(ry)	MAX
Mediastinum	MEDIAS
Medical Doctor	DR, MD
Medicine	MED
Metastatic, Metastases	MET, METS
Microscopic	MICRO
Middle Lobe	ML
Millimeter	MM
Million Electron Volts	MEV
Minimum	MIN
Moderate	MOD
Moderately Differentiated	MD, MOD DIFF
Modified Radical Mastectomy	MRM
Negative	NEG (OR -)
Neurolgoy	NEURO
No Evidence of Disease	NED
Normal	NL
No Significant Findings	NSF
Not Applicable	NA
Not Otherwise Specified	NOS

Not Recorded	NR
Obstructed (-ing, -ion)	OBST
Operation	OP
Operative Report	OP REPORT
Outpatient	OP
Packs per Day	PPD
Palpated (-able)	PALP
Papanicolaou Smear	PAP
Papillary	PAP
Past Medical History	PMH
Pathology	PATH
Patient	PT
Pelvic Inflammatory Disease	PID
Percutaneous	PERC
Physical Examination	PE
Platelets	PLT
Pleural effusion	PL E
Poorly Differentiated	PD, POOR DIFF
Positive	POS (or +)
Positron Emission Tomography	PET
Possible	POSS
Posterior	POST
Posteroanterior	PA
Postoperative (-ly)	PO, POSTOP
Preoperative (-ly)	PREOP
Primary	PRIM
Probable (-ly)	PROB
Progesterone Receptor (Assay)	PR(A)
Pulmonary	PULM
Pulmonary Artery	PA
Radiation	RAD
Radiation Absorbed Dose	RAD
Radiation Therapy	RT/XRT
Radical	RAD
Radioimmunoassay	RIA
Radium	RA
Red Blood Cells	RBC
Resection	RESEC
Respiratory	RESPIR
Right	R, RT
Right Lower Extremity	RLE
Right Lower Lobe	RLL
Right Lower Quadrant	RLQ

Right Middle Lobe	RML
Right Salpingo-oophorectomy	RSO
Right Upper Extremity	RUE
Right Upper Lobe	RUL
Right Upper Quadrant	RUQ
Rule Out	RO, R/O
Sacral Vertebra	S1-S5
Salpingo-oophorectomy	SO
Skilled Nursing Facility	SNF
Specimen	SPEC
Split Thickness Skin Graft	STSG
Small	SM, SML
Small Bowel	SB, SML BWL
Social Security Death Index	SSDI
Spine:	
Cervical	C-SPINE
Lumbar	L-SPINE
Sacral	S-SPINE
Thoracic	T-SPINE
Squamous	SQ, SQUAM
Squamous Cell Carcinoma	SCC
Stage	STG
Status Post	S/P
Subcutaneous	SUB-Q, SUBQ, SQ
Superior Vena Cava	SVC
Surgery, Surgical	SURG
Suspect, Suspicious	SUSP
Symptoms	SX
Thoracic	T-SPINE
Thoracic Vertebra	T1-T12
Topography	TOPOG
Total Abdominal Hysterectomy-	
Bilateral Salpingo-oophorectomy	TAH-BSO
Total Vaginal Hysterectomy	TVH
Transitional Cell Carcinoma	TCC
Transurethral Resection	TUR
Transurethral Resection Bladder (tumor)	TURB(T)
Transurethral Resection Prostate	TURP
Treatment	RX, TX
Tumor Size	TS
Undifferentiated	UNDIFF
Unknown	UNK
Upper Extremity	UE

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

SYMBOLS:

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

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

APPENDIX J - ICD-O-3 ERRATA AND CLARIFICATIONS

These can be found at: http://www.seer.cancer.gov/icd-o-3/.

APPENDIX K - REVISED RACE CODING RULES

(Effective with 2004 diagnoses)

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

All resources in the facility, including the medical record, face sheet, physician and nursing notes, photographs, and any other sources, must be used to determine race. If a facility does not print race in the medical record but does maintain it in electronic form, the electronic data must also be reviewed. Recommendation: document how the race code was determined in a text field.

Coding Instructions

1. Code the primary race(s) of the patient in fields Race 1, Race 2, Race 3, Race 4, and Race 5. The five race fields allow for the coding of multiple races consistent with the Census 2000. Rules 2 - 8 further specify how to code Race 1, Race 2, Race 3, Race 4 and Race 5.

2. If a person's race is a combination of white and any other race(s), code the appropriate other race(s) first and code white in the next race field.

3. If a person's race is a combination of Hawaiian and any other race(s), code Race 1 as 07 Hawaiian and code the other races in Race 2, Race 3, Race 4, and Race 5 as appropriate.
   Example*:* Patient is described as Japanese and Hawaiian. Code Race 1 as 07 Hawaiian, Race 2 as 05 Japanese, and Race 3 through Race 5 as 88.

4. If the person is not Hawaiian, code Race 1 to the first stated non-white race (02-98).
   Example: Patient is stated to be Vietnamese and Black. Code Race 1 as 10 Vietnamese, Race 2 as 02 Black, and Race 3 through Race 5 as 88.
   Note**:** in the following scenarios, only the race code referred to in the example is coded. For cases diagnosed after January 1, 2000, all race fields must be coded.

5. The fields Place of Birth, Race, Marital Status, Name, Maiden Name, and Hispanic Origin are inter-related. Use the following guidelines in priority order:
   a. Code the patient's stated race, if possible. Refer to Appendix "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" for guidance.
   Example 1*:* Patient is stated to be Japanese. Code as 05 Japanese.
   Example 2: Patient is stated to be German-Irish. Code as 01 White.
   Example 3: Patient is described as Arabian. Code as 01 White.
   Exception*:* When the race is recorded as Oriental, Mongolian, or Asian (coded to 96 Other Asian) and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation, code the race based on birthplace information.

Example 4: The person's race is recorded as Asian and the place of birth is recorded as Japan. Code race as 05 Japanese because it is more specific than 96 Asian, NOS.
Example 5: The person describes himself as an Asian-American born in Laos. Code race as 11 Laotian because it is more specific than 96 Asian, NOS.

6. If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race, other than to list the non-white race(s) first.
***Example*:** The patient is described as Asian-American with Korean parents. Code race as 08 Korean because it is more specific than 96 Asian [-American].

7. If no race is stated in the medical record, or if the stated race cannot be coded, review the documentation for a statement of a race category.
Example 1*:* Patient described as a black female. Code as 02 Black.
Example 2: Patient describes herself as multi-racial (nothing more specific) and nursing notes say "African-American." Code as 02 Black.
Example 3: Patient states she has a Polynesian mother and Tahitian father. Code Race 1 as 25 Polynesian, Race 2 as 26 Tahitian and Race 3 through Race 5 as 88.

8. If race is unknown or not stated in the medical record and birth place is recorded, in some cases race may be inferred from the nationality. Refer to the Appendix entitled "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" to identify nationalities from which race codes may be inferred.
Example 1: Record states: "this native of Portugal..." Code race as 01 White per the Appendix.
Example 2*:* Record states: "this patient was Nigerian..." *Code race as 02 Black* per the Appendix.
Exception: If the patient's name is incongruous with the race inferred on the basis of nationality, code Race 1 through Race 5 as 99, Unknown.
Example 1: Patient's name is Siddhartha Rao and birthplace is listed as England. Code Race 1 through Race 5 as 99 Unknown.
Example 2: Patient's name is Ping Chen and birthplace is Ethiopia. *Code* Race 1 through Race 5 as 99 Unknown.

9. Use of patient name in determining race:
a. Do not code race from name alone, especially for females with no maiden name given.
b. In general, a name may be an indicator of a racial group, but should not be taken as the only indicator of race.
c. A patient name may be used to identify a more specific race code.
***Example 1*:** Race reported as Asian, name is Hatsu Mashimoto. Code race as 05 Japanese.
Example 2*:* Birthplace is reported as Guatemala and name is Jose Chuicol [name is identified as Mayan]. Code race as 03 Native American
d. A patient name may be used to infer Spanish ethnicity or place of birth, but a Spanish name alone (without a statement about race or place of birth) cannot be used to determine the race code. Refer to ethnicity guidelines for further information.
Example: Alice Gomez is a native of Indiana (implied birthplace: United States). Code Race 1 through Race 5 as 99 Unknown, because nothing is known about her race.

10. Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually white. Do NOT code a patient stated to be Hispanic or Latino as 98 Other Race in Race 1 and 88 in Race 2 through Race 5.
    Example: Sabrina Fitzsimmons is a native of Brazil. Code race as 01 White per Appendix.

11. When the race is recorded as Negro or African-American, code race as 02 Black.

12. Code 03 should be used for any person stated to be Native American or [western hemisphere] Indian, whether from North, Central, South, or Latin America. For Central, South, or Latin American Indians, see additional ethnicity coding guidelines under Spanish Surname or Origin.

13. Death certificate information may be used to supplement antemortem race information only when race is coded unknown in the patient record or when the death certificate information is more specific.
    Example 1: In the cancer record Race 1 through Race 5 are coded as 99 Unknown. The death certificate states race as black. Change cancer record for Race 1 to 02 Black and Race 2 through Race 5 to 88.
    Example 2: Race 1 is coded in the cancer record as 96 Asian. Death certificate gives birthplace as China. Change Race 1 in the cancer record to 04 Chinese and code Race 2 through Race 5 as 88.

Race and nationality descriptions from the 2000 Census and Bureau of Vital Statistics can be found at:

http://seer.cancer.gov/manuals/2010/SPCSM_2010_AppendixD.pdf

APPENDIX L - COMMON HISPANIC SURNAMES

A list of frequently occurring heavily Hispanic surnames compiled by the U.S. Census Bureau may be found at:

http://www.census.gov/population/documentation/twpno13.pdf on page 20.

APPENDIX M - SUPPLEMENTAL CASEFINDING LIST

These ICD-9-CM codes may also be used for casefinding. Many of these codes are for diseases associated with cancer or represent neoplasm-related secondary conditions. Experience among the SEER registries has proven that using the supplementary list significantly improves casefinding outcomes for benign brain and CNS tumors, hematopoietic and lymphoid neoplasms, and other reportable diseases. It is recommended that each registry screen cases using the supplementary list as time permits.

ICD-9-CM Supplemental Casefinding List (Effective Date: 01/01/2013)

Code	Description
042	Acquired Immunodeficiency Syndrome (AIDS)
079.4	Human papillomavirus
079.50 - 079.59	Retrovirus (HTLV, types I, II, and 2)
209.40 - 209.69	Benign carcinoid tumors
210.0 - 229.9	Benign neoplasms (except 225.0-225.9, 227.3, 227.4, 227.9, 228.02, and 228.1)
235.0 - 236.6, 238.0 - 239.9	Neoplasms of uncertain behavior (except 236.0, 238.4, 238.6, 238.71-238.79, 239.6, 239.7, 239.81, and 239.89)
253.6	Syndrome of inappropriate secretion of antidiuretic hormone (part of neoplastic syndrome)
258.02 - 258.03	Multiple endocrine neoplasia (MEN) type IIA and IIB (rare familial cancer syndrome)
259.2	Carcinoid syndrome
259.8	Other specified endocrine disorders
273.0	Polyclonal hypergammaglobulinemia
273.1	Monoclonal gammopathy of undetermined significance (MGUS) (9765/1)
273.9	Unspecified disorder of plasma protein metabolism
275.42	Hypercalcemia (part of neoplastic syndrome)
277.88	Tumor lysis syndrome following antineoplastic drug therapy
279.00	Hypogammaglobulinemia (predisposed to lymphoma or stomach cancer)
279.02 - 279.06	Selective IgM immunodeficiency (associated w/lymphoproliferative disorders)
279.10	Immunodeficiency with predominant T-cell defect, NOS
279.12	Wiskott-Aldrich syndrome
279.13	Nezelof's syndrome
279.2 - 279.9	Combined immunity deficiency - unspecified disorder of immune mechanism
284.81	Red cell aplasia (acquired, adult, with thymoma)

284.89	Other specified aplastic anemias due to drug (chemotherapy or immunotherapy), infection, radiation
285.0	Sideroblastic anemia
285.22	Anemia in neoplastic disease
285.3	Anti-neoplastic chemotherapy induced anemia
288.03	Drug induced neutropenia
289.83	Myelofibrosis (NOS)
289.89	Other unspecified diseases of blood and blood-forming organs
323.81	Encephalomyelitis; specified cause NEC (part of neoplastic syndrome)
338.3	Neoplasm related pain (acute, chronic); cancer associated pain
379.59	Opsoclonia (part of neoplastic syndrome)
511.81	Malignant pleural effusion
528.01	Musositis due to antineoplastic therapy
630	Hydatidiform Mole
686.01	Pyoderma gangrenosum (part of neoplastic syndrome)
695.59	Sweet's syndrome (part of neoplastic syndrome)
701.2	Acanthosis nigricans (part of neoplastic syndrome)
710.3	Dermatomyositis (part of neoplastic syndrome)
710.4	Polymyositis (part of neoplastic syndrome)
785.6	Enlargment of lymph nodes
789.51	Malignant ascites
790.93	Elevated prostate specific antigen (PSA)
795.81 - 795-89	Abnormal tumor markers
999.31	Infection due to central venous catheter
999.81	Extravasation of vesicant chemotherapy
E879.2	Adverse effect of radiation therapy
E930.7	Adverse effect of antineoplastic therapy
E933.1	Adverse effect of immunosuppressive drugs
V07.31, V07.39	Other prophylactic chemotherapy
V07.8	Other specified prophylactic measure
V12.72	History of colonic polyps
V15.3	Irradiation; previous exposure to therapeutic of ionizing radiation
V42.81 - V42.82	Organ or tissue replaced by transplant, bone marrow transplant
V51.0	Encounter for breast reconstruction following mastectomy
V52.4	Breast prosthesis and implant
V58.0 - V58.12	Encounter for radiation and chemotherapy
V58.42	Aftercare following surgery for neoplasm
V66.1 - V66.2	Convalescence following radiotherapy and/or chemotherapy

V67.1 - V67.2	Radiation and chemotherapy follow up
V71.1	Observation for suspected malignant neoplasm
V76.0 - V76.9	Special screening for malignant neoplasm
V78.0 - V78.9, V82.9	Special screening for disorders of blood and blood-forming organs
V84.01 - V84.09	Genetic susceptibility to malignant neoplasm
V84.81	Genetic susceptibility to multiple endocrine neoplasia (MEN)
V86.0 - V86.1	Estrogen receptor status
V87.41	Personal history of anti-neoplastic chemotherapy