

OHIO
CANCER
INCIDENCE
SURVEILLANCE
SYSTEM



**REPORTING SOURCE
PROCEDURE MANUAL
VERSION 7**

Effective for cases diagnosed on or after January 1, 2010

OCISS Reporting Source Number ____ _

**Ohio Cancer Incidence Surveillance System
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An Equal Opportunity Employer/Provider

The Ohio Department of Health Mission Statement:

“To protect and improve the health of all Ohioans by preventing diseases, promoting good health and assuring access to quality health care.”

The Ohio Cancer Incidence Surveillance System Mission Statement:

“To provide high quality cancer incidence and mortality data, and analyses; to monitor the occurrence of cancer, and to identify high-risk populations for the various types of cancer; to support qualified research efforts and the design and evaluation of interventions concerned with the prevention, early detection and control of cancer in Ohio.”

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SECTION A GUIDELINES

I. Who Reports

II. What to Report

- A. Case Definition**
- B. Reportable Cases**
- C. Cases NOT Reportable to OCISS**
- D. Reference Materials**
- E. OCISS Staff - Individual Contact Information**

III. How to Report

- A. Requirements for Submitting Data via Gateway**

I. WHO REPORTS

Each physician, dentist, hospital or person providing diagnostic or treatment services to patients with cancer shall report each case of cancer to the Ohio Cancer Incidence Surveillance System (OCISS) at the Ohio Department of Health (ODH). Any reporting source may elect to report to the OCISS through an existing cancer registry if the registry meets the reporting standards established by the director of ODH and consents to report those cases to the OCISS. (See Appendix 1 - Ohio Revised Code Sections 3701.261-3701.264 and Section 3701.99 and Ohio Administrative Code Chapter 3701-4.)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted Aug. 21, 1996. The secretary of Health and Human Services is required by HIPAA to publicize standards for the electronic exchange, privacy and security of health information. The privacy standards are known as the “Privacy Rule.” As OCISS is a public health surveillance system, it is not subject to HIPAA, per 42 USC 1320d-7(B), and disclosing data, or reporting, to OCISS is not a violation of HIPAA, per Id. and 45 CFR § 164.512(b). To view the relevant sections of HIPAA see <http://www.access.gpo.gov/uscode/uscmain.html>. To view the full text of the HIPAA “Privacy Rule,” see <http://www.hhs.gov/ocr/AdminSimpRegText.pdf>.

Cancer cases must be reported to the OCISS within six months of date of first contact with your facility for this cancer. The OCISS urges facilities to report cancer cases monthly.

MONTH of FIRST CONTACT at YOUR FACILITY for this CANCER	MONTH Cases MUST be REPORTED to OCISS
January (1)	July (7)
February (2)	August (8)
March (3)	September (9)
April (4)	October (10)
May (5)	November (11)
June (6)	December (12)
July (7)	January (1)
August (8)	February (2)
September (9)	March (3)
October (10)	April (4)
November (11)	May (5)
December (12)	June (6)

If information is limited to a description, use the following:

DESCRIPTIVE TERM USED for Time of First Contact at Your Facility for This Cancer	MONTH Cases MUST be REPORTED to OCISS
Winter	August
Spring	November
Summer	February
Fall	May

II. WHAT TO REPORT

A. Case Definition

“Reportable Case” means any primary malignant neoplasm, with the exception of basal and squamous carcinoma of the skin and carcinoma in-situ of the cervix, diagnosed and/or treated in any person in Ohio on and after Jan. 1, 1992; Hematopoietic Diseases, M-9731/3 through M-9764/3 and M-9920/3 through M-9989/3 or “newly reportable hematopoietics,” diagnosed on or after Jan. 1, 2001; and all cases of benign and borderline intracranial and central nervous system (CNS) tumors diagnosed on or after Jan. 1, 2004.

B. Reportable Cases:

(1) All malignant cancers, cases with a behavior code of /2, *in situ*; or /3, invasive; as defined in the *International Classification of Diseases for Oncology, Third Edition* (ICD-O-3) are reportable neoplasms.

(2) Any primary malignant neoplasms diagnosed on or after Jan. 1, 1992.

(3) Myelodysplastic Syndromes (MDSs) including refractory anemias (M-9980, M-9982 through M-9984, M-9989). MDSs arise in the bone marrow and are characterized by abnormal growth of blood cells in the bone marrow. MDSs are clonal diseases, meaning a large population of exactly alike abnormal cells arise from a single abnormal cell.

Chronic Myeloproliferative Diseases (CMPDs) including polycythemia vera and thrombocythemias (M-9950, M-9960 through M-9962). CMPDs also arise in the bone marrow. CMPDs are the overproduction of blood cells by the bone marrow. Polycythemia vera is the overproduction of red blood cells and thrombocythemia is the production of too many platelets. CMPDs sometimes become acute leukemia, or the production of too many white blood cells.

(4) All benign and borderline primary intracranial and CNS tumors, cases with a behavior code of /0, benign; or /1, uncertain whether benign or malignant; diagnosed on or after Jan. 1, 2004, for the following sites: meninges (C70._), brain (C71._), spinal cord, cranial nerves and other parts of the central nervous system (C72._), pituitary gland (C75.1), craniopharyngeal duct (C75.2) and pineal gland (C75.3) are reportable.

(5) The following histologies: M-8000/2 and/or M-8000/3 through M-8004/2 and/or M-8004/3, Neoplasms, malignant, NOS; M8010/2 and/or M-8010/3 through M8045/2 and/or M-8045/3, Epithelial carcinomas; M-8050/2 and/or M-8050/3 through M-8082/2 and/or M-8082/3, Papillary and squamous cell carcinomas; M-8090/2 and/or M8090/3 through M-8110/2 and/or 8110/3, Basal cell carcinomas of the **skin** of the **genital sites**;

- (a) Labium majus, C51.0;
- (b) Labium minus, C51.1;
- (c) Clitoris, C51.2;
- (d) Overlapping lesion of vulva, C51.8;
- (e) Vulva, NOS, C51.9;
- (f) Vagina, NOS, C52.9;
- (g) Prepuce, C60.0;
- (h) Penis, NOS, C60.9; and
- (i) Scrotum, NOS, C63.2.

- (6) The following list is intended to assist personnel in all health care settings who use ICD-9-CM* codes to codify diagnoses to find and report reportable neoplasms.

** ICD-9-CM Codes	Diagnosis
140.0-208.9	Malignant Neoplasm
225.0-225.9	Benign Neoplasm of Brain and Spinal Cord
227.3-227.4	Benign Neoplasm of Pituitary Gland, Pineal Gland and Other Intracranial Endocrine-related Structures
230.0-234.9	Carcinoma <i>In Situ</i>
237.0-237.9	Neoplasm of Uncertain Behavior [Borderline] of Endocrine Glands and Nervous System
238.4	Polycythemia Vera
238.6	Solitary Plasmacytoma
238.6	Extramedullary Plasmacytoma
*238.71	Essential Thrombocythemia
*238.72	Low Grade Myelodysplastic Syndrome Lesions
*238.73	High Grade Myelodysplastic Syndrome Lesions
*238.74	Myelodysplastic Syndrome with 5q Deletion
*238.75	Myelodysplastic Syndrome, Unspecified
*238.76	Myelofibrosis with Myeloid Metaplasia
*238.79	Other Lymphatic and Hematopoietic Tissues
273.2	Gamma Heavy Chain Disease; Franklin's Disease
273.3	Waldenstrom's Macroglobulinemia
288.3	Hypereosinophilic Syndrome
*289.83	Myelofibrosis
*759.06	Papanicolaou Smear of Cervix with Cytologic Evidence of Malignancy (without histologic confirmation) (positive Pap smear)
V58.0	Encounter for Radiotherapy
V58.11	Encounter for Antineoplastic Chemotherapy
V58.12	Encounter for Antineoplastic Immunotherapy

* New codes effective 10/1/2006.

** *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)*, U.S. Department of Health and Human Services, Public Health Service - Health Care Finance Administration; DHHS Publication No. (PHS) 80-1260.

- (7) Class of Case 00-22, analytic cases, as well as non-analytic Class of Case 32, 35, 37, and 38 are reportable to OCISS.

Cases diagnosed at the reporting facility and/or administered any of the first course of treatment there on or after Jan. 1, 1996, are analytical. A network clinic or outpatient center belonging to the reporting facility is considered part of the reporting facility.

From *FORDS: Revised for 2010 (Revised 2010)*:

Codes

Class of Case Definitions	
Case	Includes
Analytic Classes of Case (Required by CoC to be abstracted by accredited programs)	
Initial diagnosis at reporting facility	
Class 00	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
Class 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
Class 11	Initial diagnosis in staff physician's office AND part of first course treatment was done at the reporting facility
Class 12	Initial diagnosis in staff physician's office AND all first course treatment or a decision not to treat was done at the reporting facility
Class 13	Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility
Class 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	
Class 20	Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS
Class 21	Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility
Class 22	Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility
Classes of Case not required by CoC to be abstracted (May be required by Cancer Committee, state or regional registry, or other entity)	
Patient appears in person at reporting facility	
Class 30	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, staging workup after initial diagnosis elsewhere)
Class 31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care
Class 32	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence
Class 33	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only
Class 34	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility
Class 35	Case diagnosed before program's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility
Class 36	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility

Class 37	Case diagnosed before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility
Class 38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death

Codes

Patient does not appear in person at reporting facility	
Class 40	Diagnosis AND all first course treatment given at the same staff physician's office
Class 41	Diagnosis and all first course treatment given in two or more different staff physician offices
Class 42	Non-staff 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 (for example, hospital abstracts cases from an independent radiation facility)
Class 43	Pathology or other lab specimens only
Class 49	Death certificate only
Class 99	Non-analytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases).

Examples

Code	Reason
32	After treatment failure, the patient was admitted to the facility for supportive care
11	Patient was diagnosed by a staff physician, received radiation at another facility, then underwent surgical resection at the reporting facility
42	Patients from an unaffiliated, free-standing clinic across the street that hospital abstracts with its cases because many physicians work both at the clinic and the hospital.

(8) Cases Clinically Diagnosed are Reportable.

From *The Surveillance Epidemiology and End Results (SEER) Program Coding and Staging Manual 2004, Revision 1, Released Aug. 14, 2006*, Introduction and General Guidelines, Page 3: In the absence of a histologic or cytologic confirmation of a reportable cancer, accession a case based on the **clinical diagnosis** (when a recognized medical practitioner says the patient has a cancer or carcinoma). A clinical diagnosis may be recorded in the final diagnosis on the face sheet or other parts of the medical record.

Note: A pathology report always takes precedence over a clinical diagnosis. If the patient has a negative biopsy, the case would not be reported.

Note: If the histology code for a case is listed in ICD-O-3 with a behavior code of /0, benign; and/or /1, uncertain whether benign or malignant; but a pathology report indicates a malignancy, whether in-situ or invasive, the case is considered to be reportable with the behavior code changed to /2, *in-situ*, or /3, invasive. For example: Chondroma is listed in the ICD-0-3 as M-9220/0, NOS (C40.0, C41.9). Usually this is a benign case. However, if the pathologist lists the case as "malignant chondroma," the histology code would be changed to M-9220/3.

Exception 1: If the physician treats a patient for cancer in spite of the negative biopsy, accession the case.

Exception 2: If enough time has passed that it is reasonable to assume the physician has seen the negative pathology, but the clinician continues to call this a reportable disease, accession the case. A reasonable amount of time would be equal to or greater than six months.

(9) Ambiguous Terms that are Considered as Diagnostic of Cancer and therefore Reportable:

Ambiguous terminology may originate from any source document, such as pathology report, radiology report, or from a clinical report. The terms listed below are considered as diagnostic of cancer, and therefore, REPORTABLE.

Ambiguous Terms that are Considered as Diagnostic of Cancer
Apparent(ly)
Appears (effective with cases diagnosed 1/1/98 and later)
Comparable with (effective with cases diagnosed 1/1/98 and later)
Compatible with (effective with cases diagnosed 1/1/98 and later)
Consistent with
Favor(s)
Malignant appearing (effective with cases diagnosed 1/1/98 and later)
Most likely
Presumed
Probable
Suspect(ed)
Suspicious (for)
Typical of

Examples of Diagnostic Terms:

- The inpatient/outpatient discharge summary documents a chest X-ray *consistent with carcinoma* of the right upper lobe. The patient refused further workup or treatment. *Consistent with carcinoma* is indicative of cancer.
- The mammogram report states *suspicious for malignancy*. *Suspicious for malignancy* is indicative of cancer.

(10) Case Ascertainment Source Documents

In a hospital, registry source documents can include the items listed below. The source documents may vary in individual institutions. No single review can identify all cancer cases diagnosed or treated in a health care facility. Reliance on multiple sources is necessary to obtain a complete description of the patient’s cancer experience. For example, review reports from diagnostic tests, surgery, pathology and treatment summaries. Review all documents and reports, where available, for all patients, whether **inpatients** or **outpatients**.

- (A) Admission and Discharge Documents and Reports
- (B) Disease/Diagnostic Indices - (See the ICD-9-CM list of Reportable Neoplasms on Page 5.) Disease or Diagnostic Indices are listings, usually computerized, of patients discharged from the hospital, organized by disease or diagnosis code, usually ICD-9-CM, and usually prepared by the Health Information Department.
- (C) Pathology Reports.
- (D) Cytology Reports - Cytology is the microscopic review of cells in body fluids obtained from aspirations, washings, scrapings, and smears. Cytology is usually a function of the Pathology Department. The Cytology Report is the documentation of cells in the body fluids and their diagnosis.

- (E) Radiology Reports - Radiology is the use of medical imaging technologies to diagnose and sometimes treat diseases and includes, but is not limited to, the following:
 - (1) computed radiography (CR)
 - (2) digital radiography (DR)
 - (3) fluoroscopy
 - (4) angiography
 - (5) computed tomography (CT) scans
 - (6) ultrasound
 - (7) magnetic resonance imaging (MRI)
 - (8) nuclear medicine - including, but not limited to, positron emission tomography (PET) scans, single photon emission computerized tomography (SPECT) scans, bone scans and sentinel lymph node biopsies
- (F) Radiation Oncology Logs - The Radiation Oncology Department or Radiation Therapy Department is the section of a health care facility that treats patients with beam radiation, teletherapy and/or brachytherapy, a type of radiation therapy where a sealed radiation source, usually in the form of capsules or “seeds,” is placed in direct contact with the tumor.
- (G) Medical Oncology Logs - The Medical Oncology Department is responsible for administering chemotherapy, hormonal therapy and biological therapy to patients to diagnose and/or treat cancer.
- (H) Autopsy Documents and Hospital Death Certificates.
- (I) (See Appendix 2 - How to Use Ambiguous Terminology for Case Ascertainment.)

(11) Different Names for Malignancies

To help you avoid missing cases because the diagnosis does not say carcinoma, sarcoma, lymphoma, leukemia, malignant or anything else that would lead you to believe the case is reportable, the following list of terms are reportable malignant entities. All of these diagnoses are listed in ICD-O-3 with a behavior of /2 or /3. The list was reviewed for accuracy by Juan Carlos Felix, MD., USC Pathologist.

Acute myelofibrosis	(Franklin's Disease)	Mullerian mixed tumor
Acute panmyelosis	Germ cell tumor or germinoma	Mycosis fungoides
Adamantinoma of long bones	Glioma	Multiple myeloma
Adenoacanthoma	Grawitz tumor (kidney)	Nephroma
Alpha heavy chain disease	Hepatoblastoma	Neuroectodermal tumor
Ameloblastoma	Hepatoma, NOS	Neuroepithelioma
Angioendotheliomatosis	Histiocytosis X, acute or	Olfactory neurogenic tumor
Askin tumor	differentiated progressive	Oligodendroglioma
Astrocytoma	Hodgkin's disease	Paget's disease, extramammary
Benign brain	Hutchinson's freckle	Peripheral neuroectodermal
Blastoma, NOS	Hypernephroma	tumor
Bowen's disease (genitalia)	Immature teratoma	Phyllodes tumor, malignant
Carcinoid tumor (except of	Immunoproliferative disease	Plasma cell tumor or myeloma
appendix)	Immunoproliferative	Plasmacytoma
Chordoma	small intestinal disease	Polyembryoma
Chorioepithelioma	Klatskin tumor	Polyvesicular vitelline tumor
Chorionepithelioma	Krukenberg tumor	Precancerous melanosis
Dermatofibrosarcoma	Letterer-Siew disease	Primitive neuroectodermal
protuberans	Linitis plastica (usually	tumor
DiGuglielmo's syndrome or	stomach)	Queyrat erythroplasia
disease	Lentigo maligna	Schmincke tumor
Dysgerminoma	Lobular neoplasia (breast)	Seminoma
Endodermal sinus tumor	Lymphoepithelioma	Sezary's disease or syndrome
Ependymoma	Macroglobulinemia,	Synovioma
Epithelioma NOS	Waldenstrom's	Triton tumor
Erythremia, acute & chronic	Medulloepithelioma	Waldenstrom's
Erythremic myelosis	Merkel cell tumor	macroglobulinemia
Erythroplasia, Queyrat's	Mesodermal mixed tumor	Wilms tumor
Esthesioneurocytoma	Mesonephroma	Wuchernde Struma Langhans
Esthesioneuroepithelioma	Mesothelioma	Yolk sac tumor
Gamma heavy chain disease	Mixed germ cell tumor	

NOTE: Some tumors have uncertain biological behavior. Examples are islet cell tumors of the pancreas and ovarian neoplasms such as Brenner tumor and Sertoli-Leydig tumor. The pathology report may not state malignant tumor, so it is necessary to review the medical records to determine if the tumor is benign or malignant, i.e., invasion or metastatic spread would indicate malignant behavior.

C. Cases NOT Reportable to OCISS

NOTE: The following cases are **NOT** reportable to OCISS but, in fact, may be reportable to your facility.

- (1) Carcinoma *in-situ* of the cervix (CIS) and intraepithelial neoplasia grade III (8077/2) of the cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III) and anus (AIN III) are not reportable to the OCISS.
- (2) Malignant primary skin cancers (C44._) with histology codes M-8000/2 and/or M-8000/3 through M-8110/2 and/or M-8100/3 are not reportable to the OCISS.
- (3) Patients seen only in consultation to confirm a diagnosis or treatment plan are not reportable to the OCISS.
- (4) Patients who receive transient care to avoid interrupting a course of therapy started elsewhere are not reportable to the OCISS.
- (5) Ambiguous terms that are **NOT** considered diagnostic of cancer without additional information

Terms that DO NOT Constitute a Diagnosis <i>without additional information</i>
Cannot be ruled out
Equivocal
Possible
Potentially malignant
Questionable
Rule out
Suggests
Worrisome
May represent

Exception: If **cytology** is reported as *suspicious*, do not interpret this as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician’s clinical impression of cancer supports the cytology findings.

Examples of Non-diagnostic Terms:

- The inpatient/outpatient discharge summary documents a chest X-ray *consistent with neoplasm* of the right upper lobe. The patient refused further workup or treatment. *Consistent with neoplasm* is not indicative of cancer. While “consistent with” can indicate involvement, “neoplasm” without specification of malignancy is not considered diagnostic.
- Final diagnosis is reported as *possible carcinoma* of the breast. *Possible* is not a diagnostic term for cancer.

NOTE: See Appendix 2 - How to Use Ambiguous Terminology for Case Ascertainment.

D. Reference Materials (Updated 2010)

NOTE: Publications Needed to Report Accurate, Complete and Timely Cancer Data to the Ohio Cancer Incidence Surveillance System (OCISS):

(1.) Abstracting and Coding Guide for the Hematopoietic Diseases: Including ICD-O-3 Codes, M-9731/3 through M-9764/3, M-9920/3 through M-9989/3 (Red Heme Diseases Book);

National Institutes of Health, National Cancer Institute, SEER Program; May 2002; T-007; NIH Publication No. 02-5146

Effective for All Cases Diagnosed 1/1/2001 and Later

Order at: <http://seer.cancer.gov/cgi-bin/pubs/order1.pl?CODING,BOOK,CONV,MONO,CSR,ABOUT>

(2.) Treatment Errata for Abstracting and Coding Guide for the Hematopoietic Diseases;

NIH Publication 03-5146; Errata Release Date: 10/1/2005;

Effective for All Cases Diagnosed 1/1/2005 and Later; 1 page

Download at: http://seer.cancer.gov/manuals/errata_hemediseases_%2010012005.pdf

(3.) American Joint Committee on Cancer (AJCC) Cancer Staging Manual, Seventh Edition (AJCC 7); ISBN: 978-0-387-88442-4; (Effective for Cases Diagnosed on or after January 1, 2010)

Order at: <http://www.springer.com/west/home?SGWID=4-102-0-0-0>

(Enter 0387952713 in Search)

\$44.95

Contact Information:

Springer New York, LLC

Customer Service

P. O. Box 2485

Secaucus, NY 07096-2485

Telephone: 800-777-4643

Telephone: 212-460-1500 (8:30a.m.-5:30p.m. ET Weekdays)

Fax: 201-348-4505

E-mail: service-ny@springer.com

(4.) Collaborative Staging Manual and Coding Instructions, Parts I & II; Version 2; (January 2010)

Download at: <http://www.cancerstaging.org/cstage/manuals.html> or

Order a CS Manual Printed Package (includes: CS Manual Parts I and II, Version 01.04.00;

Binder; Printed Dividers and Free Shipping) at: <http://www.ncra-usa.org/store/index.htm#pubs6>

\$85 NCRA member

\$125 non-member

Order CS Dividers from the Louisiana Cancer Registrars Association at <http://www.lcra-usa.org>. \$27.95/set.

(5.) Data Collection of Primary Central Nervous Tumors; National Program of Cancer Registries Training Materials 2004, Atlanta, GA; Department of Health and Human Services, Centers for Disease Control and Prevention, 2004

Effective for All Cases Diagnosed 1/1/2004 and Later

Download at: <http://www.cdc.gov/cancer/npcr/training/pdfs/braintumorguide.pdf>

(6.) Facility Oncology Registry Data Standards (FORDS) Manual – Revised for 2010 (Revised 2010) FORDS: Revised for 2009 (Revised 11/08);

American College of Surgeons; Commission on Cancer

Download at: <http://www.facs.org/cancer/coc/fordsmanual.html>.

(7.) International Classification of Diseases for Oncology, 3rd Edition, 2000 (ICD-O-3);

World Health Organization; Geneva, 2000

Order at:

WHO Press Distribution Center USA

5 Sand Creek Road

Albany, NY 12205-1400

Telephone: 518-436-9686

Fax: 518-436-7433

E-mail: QCORP@compuserve.com

ISBN-10: 9241545348

ISBN-13: 9789241545341

\$54

(8.) The 2007 Multiple Primary and Histology Coding Rules, Revised May 6, 2008;

NCI, SEER Program; Bethesda, MD

Effective for All Cases Diagnosed Jan. 1, 2007, and Later

Download at: <http://seer.cancer.gov/tools/mphrules/download.html>

(9.) Surveillance Epidemiology and End Results (SEER) Summary Staging Manual, 2000 Codes and Coding Instructions;

SEER Program, National Cancer Institute, National Institutes of Health; Bethesda, MD

Effective for Cases Diagnosed between Jan. 1, 2001, and Dec. 31, 2003

Download at: <http://seer.cancer.gov/tools/ssm/>

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III. HOW TO REPORT

A. Requirements for Submitting Data via Gateway

Reporting facilities are encouraged to submit data through the Gateway. The Gateway is a secure, Web-based system that provides a reliable conduit for facilities/providers to report incident cancer cases to the OCISS. Data may be submitted either by manually abstracting the case directly over the Web, using the online form provided in Gateway or by performing a Direct File transfer (DFT), which consists of a simple file upload. The file would be produced, as it always has been, by using your facility's cancer software. Gateway does NOT replace a facility's current registry software application. Gateway is not the central registry's database software.

Cancer registrars must complete Gateway training and obtain a user ID before data can be submitted through the Gateway. OCISS has the ability to provide Live Meeting Webinars on an as-needed basis. Contact Jocelyn Wilson at Jocelyn.Wilson@odh.ohio.gov or 614-995-4520 for information on Gateway training opportunities. Additionally, for user support or other questions, please don't hesitate to contact the OCISS registrar who has been assigned to your facility. This is normally the OCISS staff person with whom you speak most frequently. (See Pages 13 and 14 for OCISS registrar individual contact information.)

1. When data are submitted via the Gateway using DFT or online abstracting, the Transmittal Form will be completed online.
2. The OCISS Gateway readily provides automatic feedback to users regarding errors, whether data were submitted by Web abstracting or DFT, that may be present in submitted data. Any potential errors will be highlighted and the registrar or individual attempting to submit data will be prompted to correct them.
3. Once a user has successfully reported cases through Gateway, i.e., all errors corrected, user may then run reports showing the quality, quantity and timeliness of data submitted.
4. Users have the ability to manage their contact information and their facility demographics.
5. For information on data items collected in Gateway, see Appendix 3 - OCISS Data Items Collected on Cases Diagnosed 1/1/2008 and After.
6. For information on data items that are derived, computed or assigned in OCISS see Appendix 4 - Items that are Part of NAACCR Record Layout and Stored in OCISS but are NOT CODED by Reporting Source.

B. Requirements for Submitting Data via Diskette, CD, E-mail or Hard Copy

In order to submit data via diskette, CD, e-mail or hard copy, please remember the following:

1. For information on data items collected in Gateway, see Appendix 3 - OCISS Data Items Collected on Cases Diagnosed 1/1/2008 and After.
2. For information on data items that are derived, computed or assigned in OCISS see Appendix 4 - Items that are Part of NAACCR Record Layout and Stored in OCISS but are NOT CODED by Reporting Source.
3. If you are submitting cases on hard copy, obtain an updated hard copy reporting form from Appendix 5 - Individual Cancer Case Reporting Form.
4. A Transmittal Form must be prepared and sent with each data submission. Before submitting data via diskette, CD, e-mail or hard copy, obtain an updated transmittal form from Appendix 6 - Cancer Case Transmittal Form.
5. If assistance is needed to complete data items, contact your OCISS registrar. Contact information is available on pages 13 and 14.
6. If submitting a disk or CD, please label those with appropriate facility reporting source number; facility name; number of disks submitted and sequence number, e.g. disk 1 of 2, or ½, or 2 of 3 depending on the number of disks and which disk it is; number of cases reported on the disk or CD; type of cases reported on disk, e.g. new or follow-up; range of diagnosis dates, with years, of cases being reported, e.g. 01/07-5/07. Do NOT tape or glue a label to the disk or CD. Write on the CD but use a label on a disk. A mailing label of adequate size is preferred to label a disk.
7. If data are submitted on diskette or CD or other electronic media, please check the disk or CD prior to sending to be sure all the data are on the disk. Please be sure the number of cases on the disk matches the number of cases on the Transmittal Form.
8. Each file submitted contains data for one, and only one, reporting source. If data are being reported for several facilities on one disk, then each facility's data must be in a separate file under that facility's reporting source number. If several facilities are reported in a single file, then only one reporting source ID number will be recognized by the OCISS central registry software. Please separate each facility's data by file so each facility reported receives proper reporting credit.
9. If new records and follow-up records are being reported for the same facility on the same disk, separate the cases into separate files. Indicate file names and contents of those files on the Transmittal Form and on the disk label and/or on the CD.

10. If data are on diskette, CD or will be sent as an e-mail attachment, pay particular attention to data security. With adoption of HIPAA it is required that all communications containing protected health information (PHI) be secured. The CDs, diskettes and many e-mail attachments sent to OCISS contain PHI. Review your facility's policies and procedures for securing and sending PHI. Information on security software is available on the Web for PGP Corporation at <http://www.pgp.com>; for 2007 WinZip International LLC at <http://www.winzip.com> and for ZixCorp at <http://www.zixcorp.com>.

11. OCISS Mailing address:
Ohio Cancer Incidence Surveillance System (OCISS)
Ohio Department of Health
246 North High Street
Columbus, OH 43215

12. OCISS E-mail address:
OCISS@odh.ohio.gov

Section B

Descriptions Of Data Fields

**Field Numbers Correspond to
Hard Copy Reporting Form
(See Appendix 5)**

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Field 1) LAST NAME Item Length: 40
 Allowable Values: Letters (Mixed Case)
 NAACCR Item #2230
 Source of Information: *OCISS*

Description
 Identifies the last name of the patient.

Rationale
 This data item is used by hospitals as a patient identifier.

- Instructions for Coding**
- Truncate name if more than 40 letters long. Hyphens are allowed. **Blanks, spaces and apostrophes are not allowed.** Do not use other punctuation.
 - Do not leave blank; code as unknown if the patient’s last name is unknown.
 - This field may be updated if the last name changes.

Examples

Code	Reason
McDonald	Mc Donald; enter as McDonald since blank not allowed.
OHara	O’Hara; enter as OHara since apostrophe not allowed.
Smith-Jones	Janet Smith marries Fred Jones and changes her last name to Smith-Jones; enter as Smith-Jones since hyphen is allowed.
UNKNOWN	If patient’s last name is not known, enter as UNKNOWN.

Field 2) FIRST NAME

Item Length: 40
 Allowable Values: Letters (Mixed Case)
 NAACCR Item #2240
 Source of Information: *OCISS*

Description

Identifies the first name of the patient.

Rationale

This data item is used by hospitals to differentiate between patients with the same last names.

Instructions for Coding

Truncate name if more than 40 letters long. Hyphens are allowed. **Blanks, spaces and apostrophes are not allowed.** Do not use punctuation.

Examples

Code	Reason
Michael	Patient's name is Michael Hogan. Enter Hogan as the last name and Michael as the first name.
UNKNOWN	If patient's first name is not known, enter as UNKNOWN.

Field 3) MIDDLE NAME (Middle Initial) Item Length: 40
 Allowable Values: Letters (Mixed Case)
 NAACCR Item #2250
 Source of Information: *OCISS*

Description

Identifies the middle name or middle initial of the patient.

Rationale

This data item helps distinguish between patients with identical first and last names.

Instructions for Coding

Truncate name if more than 40 letters long. Record the middle initial if the complete name is not provided. Hyphens are allowed. **Blanks, spaces and apostrophes are not allowed.** Do not use punctuation.

Examples

Code	Reason
David	Patient's name is Michael David Hogan. Enter Hogan as the last name, Michael as the first name, and David as the middle name.
D	Patient's name is Michael D. Hogan. Enter Hogan as the last name, Michael as the first name, and D as the middle name.
UNKNOWN	If patient does not have a middle name or initial, or if the middle name or initial are not known, enter as UNKNOWN.

Field 4) NAME SUFFIX

Item Length: 3

Allowable Values: Letters (Mixed Case)

NAACCR Item #2270

Source of Information: *NAACCR Data Dictionary, Version 12*

Description

Title that follows a patient's last name, such as a generation order or credential status (e.g., "MD," "Jr.").

Field 5) MAIDEN NAME

Item Length: 40

Allowable Values: Letters (Mixed Case)

NAACCR Item #2390

Source of Information: *OCISS*

Description

Maiden name of the female patients who are or have been married.

Rationale

This is used to link reports on a woman who changed her name between reports. It also is critical when using Spanish surname algorithms to categorize ethnicity.

Instructions for Coding

Truncate name if more than 40 letters long. Hyphens are allowed. **Spaces and apostrophes are not allowed.** The field should be left blank if the maiden name is not known or not applicable. Since a value in this field may be used by linkage software or other computer algorithms, only legitimate surnames are allowable, and any variation of “unknown” or “not applicable” is not allowed.

Field 6) ALIAS (AKA)

Item Length: 40

Allowable Values: Letters (Mixed case)

NAACCR Item #2280

Source of Information: *OCISS*

Description

Records an alternate name or “AKA” (also known as) used by the patient, if known. Note that maiden name is entered in Maiden Name (Field 5).

Field 7) SOCIAL SECURITY NUMBER

Item Length: 9
 Allowable Values: Numbers
 NAACCR Item #2320
 Source of Information: *FORDS: Revised for 2010*

Description

Records the patient's Social Security number.

Rationale

This data item can be used to identify patients with similar names.

Instructions for Coding

- Code the patient's Social Security number.
- A patient's Medicare claim number may not always be identical to the person's Social Security number.
- Code Social Security numbers that end with "B" or "D" as 999999999. The patient receives benefits under the spouse's number and this is the spouse's Social Security number.

Code	Definition
(fill spaces)	Record the patient's Social Security number without dashes.
999999999	Patient does not have a Social Security number; SSN is not available.

Field 8) MEDICAL RECORD NUMBER

Item Length: 11
 Allowable Values: Numbers and Letters
 NAACCR Item #2300
 Source of Information: *FORDS: Revised for 2010*

Description

Records the medical record number usually assigned by the reporting facility's health information management (HIM) department.

Rationale

This number identifies the patient within a reporting facility. It can be used to reference a patient record and it helps to identify multiple reports on the same patient.

Instructions for Coding

- Record the medical record number.
- When a patient enters a military hospital as a family member of a military sponsor, do not code the patient's relationship to the military sponsor in this field.

Examples

Code	Reason
-----000000	If the medical record number is fewer than 11 characters, right justify the characters and allow leading blanks.
-----RT (Radiation therapy) -----SU (One-day surgery clinic)	Record standard abbreviations for departments that do not use HIM medical record numbers.
-----UNK	The medical record number is unknown.

Field 9) DATE OF BIRTH (DOB)	Item Length: 8 NAACCR Item #240 Source of Information: <i>FORDS: Revised for 2010</i>
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Description

Identifies the date of birth of the patient.

Rationale

This data item is useful for patient identification. It is also useful when analyzing tumors according to age cohort.

Instructions for Coding

- Record the patient’s date of birth as indicated in the patient record. For single-digit day or month, record with a lead 0 (for example, September is 09). Use the full four-digit year for year.
- For *in utero* diagnosis and treatment, record the actual date of birth. It will follow one or both dates for those events.
- If only the patient age is available, calculate the year of birth from age and the year of diagnosis and leave day and month of birth unknown (for example, a 60 year old patient diagnosed in 2010 is calculated to have been born in 1950).
- If month is unknown, the day is coded unknown. If the year cannot be determined, the day and month are both coded unknown.
- If the date of birth cannot be determined at all, record the reason in *Date of Birth Flag* (NAACCR Item #241).
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about date entry in their own systems. The traditional format for *Date of Birth* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Birth* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date. The *Date of Birth Flag* (NAACCR Item #241) is used to explain why *Date of Birth* is not a known date. See *Date of Birth Flag* for an illustration of the relationships among these items.

Field 10) PLACE OF BIRTH

Item Length: 3
 Allowable Values: 000-750, 998, 999
 NAACCR Item #250
 Source of Information: *FORDS: Revised for 2010*

Description

Records the patient’s place of birth.

Rationale

This data item is used to evaluate medical care delivery to special populations and to identify populations at special risk for certain cancers.

Instructions for Coding

- Use the most specific code.
- Use the SEER Geocodes for “Place of Birth.” These codes include states of the United States as well as foreign countries.
- For SEER Geocodes, see the most recent *NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary*.

Code	Definition
000-750	SEER Geocode
998	Place of birth outside of the United States, no other detail known.
999	Place of birth unknown.

U.S.A.

State	Code	State	Code	State	Code
Alabama	037	Maine	002	Pennsylvania	014
Alaska	091	Maryland	021	Rhode Island	006
Arizona	087	Massachusetts	005	South Carolina	026
Arkansas	071	Michigan	041	South Dakota	055
California	097	Minnesota	052	Tennessee	031
Colorado	083	Mississippi	039	Texas	077
Connecticut	007	Missouri	063	Utah	084
Delaware	017	Montana	056	Vermont	004
District of Columbia	022	Nebraska	067	Virginia	023
Florida	035	Nevada	085	Washington	093
Georgia	033	New Hampshire	003	West Virginia	024
Hawaii	099	New Jersey	008	Wisconsin	051
Idaho	081	New Mexico	086	Wyoming	082
Illinois	061	New York	011		
Indiana	045	North Carolina	025		
Iowa	053	North Dakota	054	American Samoa	121
Kansas	065	Ohio	043	Guam	126
Kentucky	047	Oklahoma	075	Puerto Rico	101
Louisiana	073	Oregon	095	Virgin Islands	102

CANADA

Province	Code	Province	Code	Province	Code
Alberta	224	Northwest Territories	225	Quebec	222
British Columbia	226	Nova Scotia	221	Saskatchewan	224
Manitoba	224	Nunavut	227	Yukon	225
New Brunswick	221	Ontario	223		
Newfoundland & Labrador	221	Prince Edward Island	221		

Field 11) MARITAL STATUS

Item Length: 1

Allowable Values: 1-5, 9

NAACCR Item #150

Source of Information: *NAACCR Data Dictionary, Version 12*

Description

Code for the patient's marital status at the time of diagnosis for the reportable tumor. If the patient has multiple tumors, marital status may be different for each tumor.

Rationale

Incidence and survival with certain cancers vary by marital status. The item also helps in patient identification.

Instructions for Coding

Code	Label
1	Single (never married)
2	Married (including common law)
3	Separated
4	Divorced
5	Widowed
9	Unknown

Field 12) SEX

Item Length: 1

Allowable Values: 1-4, 9

NAACCR Item #220

Source of Information: *FORDS: Revised for 2010*

Description

Identifies the sex of the patient.

Rationale

This data item is used to compare cancer rates and outcomes by site. The same sex code should appear in each medical record for a patient with multiple tumors.

Instructions for Coding

Record the patient's sex as indicated in the medical record.

Code	Label
1	Male
2	Female
3	Other (hermaphrodite)
4	Transsexual
9	Not stated in patient record

Field 13) ADDRESS (Number and Street at Diagnosis)

Item Length: 60
 Allowable values: Numbers and Letters
 NAACCR Item #2330
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies the patient’s address (number and street) at the time of diagnosis.

Rationale

The address is part of the patient’s demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Instructions for Coding

- Record the number and street address or the rural mailing address of the patient’s usual residence when the tumor was diagnosed.
- The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. The USPS Postal Addressing Standards, Pub 28, November 2000 can be found on the Internet at <http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf>.
- Abbreviations should be limited to those recognized by the Postal Service standard abbreviations. They include, but are not limited to: AVE (avenue), BLVD (boulevard), CIR (circle), CT (court), DR (drive), PLZ (plaza), PARK (park), PKWY (parkway), RD (road), SQ (square), ST (street), APT (apartment), BLDG (building), FL (floor), STE (suite), UNIT (unit), RM (room), DEPT (department), N (north), NE (northeast), NW (northwest), S (south), SE (southeast), SW (southwest), E (east), W (west). A complete list of recognized street abbreviations is provided in Appendix C of USPS Pub 28.
- Punctuation is normally limited to periods (e.g., 39.2 RD), slashes for fractional addresses (e.g., 101 ½ MAIN ST), and hyphens when a hyphen carries meaning (e.g., 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 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (e.g., 425 FLOWER BLVD # 72).
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Do not update this data item if the patient’s address changes.
- See “Patient Address and Residency Rules” in *FORDS: Revised for 2010*, Section One, for further instructions.

Code	Definition
103 FIRST AVE SW APT 102	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an address; leave blanks between numbers and words.
UNKNOWN	If the patient’s address is unknown, enter UNKNOWN.

Field 13a) ADDRESS SUPPLEMENTAL

Item Length: 60
 Allowable values: Numbers and Letters
 NAACCR Item #2335
 Source of Information: *FORDS: Revised for 2010*

Description

Provides the ability to store additional address information such as the name of a place or facility (for example, a nursing home, or name of an apartment complex) at the time of diagnosis.

Rationale

A registry may receive the name of a facility instead of a proper street address containing the street number, name, direction, and other elements necessary to locate an address on a street file for the purpose of geocoding.

Instructions for Coding

- Record the place or facility (for example, a nursing home or name of an apartment complex) of the patient’s usual residence when the tumor was diagnosed.
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Do not use this data item to record the number and street address of the patient.
- Do not update this data item if the patient’s address changes.
- See “Patient Address and Residency Rules” in *FORDS: Revised for 2010*, Section One, for further instructions.

Code	Definition
VALLEYVIEW NURSING HOME	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an address; leave blanks between numbers and words.
(leave blank)	If this address space is not needed, then leave blank.

Field 14) CITY (City/Town of Residence at Diagnosis)

Item Length: 50
 Allowable Values: Letters
 NAACCR Item #70
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies the name of the city or town in which the patient resides at the time the tumor is diagnosed and treated.

Rationale

The city or town is part of the patient’s demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Instructions for Coding

- If the patient resides in a rural area, record the name of the city or town used in his or her mailing address.
- If the patient has multiple malignancies, the city or town may be different for subsequent primaries.
- Do not update this data item if the patient’s city or town of residence changes.
- See “Patient Address and Residency Rules” in *FORDS: Revised for 2010*, Section One, for further instructions.

Code	Definition
CITY NAME	Do not use punctuation, special characters, or numbers. The use of capital letters is preferred by the USPS; it also guarantees consistent results in queries and reporting. Abbreviate where necessary.
UNKNOWN	If the patient’s city or town is unknown.

Field 15) STATE (of Residence at Diagnosis)	Item Length: 2 Allowable Values: Uppercase Letters NAACCR Item #80 Source of Information: <i>FORDS: Revised for 2010</i>
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Description

Identifies the patient’s state of residence at the time of diagnosis.

Rationale

The state of residence is part of the patient’s demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Instructions for Coding

- Use U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province or territory in which the patient resides at the time the tumor is diagnosed and treated.
- If the patient has multiple tumors, the state of residence may be different for subsequent primaries.
- If the patient is a foreign resident, then code either XX or YY depending on the circumstance.
- Do not update this data item if the patient’s state of residence changes.

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

Common U.S. Abbreviations (refer to the ZIP Code directory for further listings)

State	Abbreviation	State	Abbreviation	State	Abbreviation
Alabama	AL	Massachusetts	MA	Tennessee	TN
Alaska	AK	Michigan	MI	Texas	TX
Arizona	AZ	Minnesota	MN	Utah	UT
Arkansas	AR	Mississippi	MS	Vermont	VT
California	CA	Missouri	MO	Virginia	VA
Colorado	CO	Montana	MT	Washington	WA
Connecticut	CT	Nebraska	NE	West Virginia	WV
Delaware	DE	Nevada	NV	Wisconsin	WI
District of Columbia	DC	New Hampshire	NH	Wyoming	WY
Florida	FL	New Jersey	NJ	United States, state unknown	US
Georgia	GA	New Mexico	NM	American Samoa	AS
Hawaii	HI	New York	NY	Guam	GU
Idaho	ID	North Carolina	NC	Puerto Rico	PR
Illinois	IL	North Dakota	ND	Virgin Islands	VI
Indiana	IN	Ohio	OH	Palau	PW
Iowa	IA	Oklahoma	OK	Micronesia	FM
Kansas	KS	Oregon	OR	Marshall Islands	MH
Kentucky	KY	Pennsylvania	PA	Outlying Islands	UM
Louisiana	LA	Rhode Island	RI	APO/FPO Armed Services America	AA
Maine	ME	South Carolina	CS	APO/FPO Armed Services Europe	AE
Maryland	MD	South Dakota	SD	APO/FPO Armed Services Pacific	AP

Canadian Provinces and Territory Abbreviations

Province/Territory	Abbreviation	Province/Territory	Abbreviation
Alberta	AB	Nunavut	NU
British Columbia	BC	Ontario	ON
Manitoba	MB	Prince Edward Island	PE
New Brunswick	NB	Quebec	QC
Newfoundland and Labrador	NL	Saskatchewan	SK
Northwest Territories	NT	Yukon	YT
Nova Scotia	NS	Canada, province unknown	CD

Field 16) POSTAL CODE (ZIP Code at Diagnosis)

Item Length: 9
 Allowable Values: Numbers Only for U.S. Residents
 NAACCR Item #100
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies the postal code of the patient’s address at diagnosis.

Rationale

The postal code is 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.

Instructions for Coding

- For U.S. residents, record the patient’s nine-digit extended postal code at the time of diagnosis and treatment.
- For Canadian residents, record the six-character postal code.
- When available, record the postal code for other countries.
- If the patient has multiple malignancies, the postal code may be different for subsequent primaries.
- Do not update this data item if the patient’s postal code changes.
- See “Patient Address and Residency Rules” in *FORDS: Revised for 2010*, Section One, for further instructions.

Code	Definition
(fill spaces)	The patient’s nine-digit U.S. extended postal code. Do not use hyphens.
60611_ _ _ _	When the nine-digit extended U.S. ZIP Code is not available, record the five-digit postal code, left-justified, followed by four blanks.
M6G2S8_ _ _	The patient’s six-character Canadian postal code left justified, followed by three blanks.
88888_ _ _ _ or 888888888	Permanent address in a country other than Canada, United States, or U.S. possessions and postal code is unknown.
99999_ _ _ _ or 999999999	Permanent address in Canada, United States or U.S. possession and postal code is unknown.

Field 17) COUNTY (County at Diagnosis) Item Length: 3
 Allowable Values: 001-997, 998, 999
 NAACCR Item #90
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies the county of the patient’s residence at the time the reportable tumor is diagnosed.

Rationale

This data item may be used for epidemiological purposes. For example, to measure the cancer incidence in a particular geographic area.

Instructions for Coding

- For U.S. residents, use codes issued by the Federal Information Processing Standards (FIPS) publication, *Counties and Equivalent Entities of the United States, Its Possessions, and Associated areas*. This publication is available in a reference library or can be accessed on the Internet through the U.S. EPA’s Envirofacts Data Warehouse and Applications Web site at <http://www.epa.gov/>.
- If the patient has multiple tumors, the county codes may be different for each tumor.
- If the patient is a non-U.S. resident and is coded XX in *State at Diagnosis* (NAACCR Item #80), then code the patient’s country of residence in this space.
- For country codes, see the current version of *NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary*.
- Do not update this data item if the patient’s county of residence changes.

Ohio County FIPS Codes

Code	County	Code	County	Code	County
001	Adams	061	Hamilton	121	Noble
003	Allen	063	Hancock	123	Ottawa
005	Ashland	065	Hardin	125	Paulding
007	Ashtabula	067	Harrison	127	Perry
009	Athens	069	Henry	129	Pickaway
011	Auglaize	071	Highland	131	Pike
013	Belmont	073	Hocking	133	Portage
015	Brown	075	Holmes	135	Preble
017	Butler	077	Huron	137	Putnam
019	Carroll	079	Jackson	139	Richland
021	Champaign	081	Jefferson	141	Ross
023	Clark	083	Knox	143	Sandusky
025	Clermont	085	Lake	145	Scioto
027	Clinton	087	Lawrence	147	Seneca
029	Columbiana	089	Licking	149	Shelby
031	Coshocton	091	Logan	151	Stark
033	Crawford	093	Lorain	153	Summit
035	Cuyahoga	095	Lucas	155	Trumbull
037	Darke	097	Madison	157	Tuscarawas
039	Defiance	099	Mahoning	159	Union
041	Delaware	101	Marion	161	Van Wert
043	Erie	103	Medina	163	Vinton
045	Fairfield	105	Meigs	165	Warren
047	Fayette	107	Mercer	167	Washington
049	Franklin	109	Miami	169	Wayne
051	Fulton	111	Monroe	171	Williams
053	Gallia	113	Montgomery	173	Wood
055	Geauga	115	Morgan	175	Wyandot
057	Greene	117	Morrow	998	Out of State
059	Guernsey	119	Muskingum	999	County Unknown

Field 18) RACE 1

Item Length: 2

Allowable Values: 01-08, 10-17, 20-22, 25-28, 30-32, 96-99

NAACCR Item #160

Source of Information: *FORDS: Revised for 2010*

Description

Identifies the primary race of the person.

Rationale

Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow for an accurate national comparison.

Instructions for Coding

- Additional races reported by the person should be coded in *Race 2*, *Race 3*, *Race 4*, and *Race 5*.
- *Race 1* is the field used to compare with race data on cases diagnosed prior to January 1, 2000.
- “Race” is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If the patient is multiracial, then code all races using *Race 2* (NAACCR Item #161) through *Race 5* (NAACCR Item #164), and code all remaining *Race* items 88.
- If the person is multiracial and one of the races is white, code the other race(s) first with white in the next race field.
- If the person is multiracial and one of the races is Hawaiian, code Hawaiian as *Race 1*, followed by the other race(s).
- A known race code (other than blank or 99) must not occur more than once. For example, do not code “Black” in *Race 1* for one parent and “Black” in *Race 2* for the other parent.
- If *Race 1* is coded 99, then *Race 2* through *Race 5* must all be coded 99.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- If *Race Coding System–Current* (NAACCR Item #170) is less than six (6) for cases diagnosed prior to January 1, 2000, then *Race 2* through *Race 5* must be blank.
- If a patient diagnosed prior to January 1, 2000, develops a subsequent primary after that date, then *Race Coding System–Current* must be six (6), and data items *Race 2* through *Race 5* that do not have specific race recorded must be coded 88.

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorroan
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean
12	Hmong	96	Other Asian, including Asian, NOS and Oriental, NOS
13	Kampuchean (Cambodian)	97	Pacific Islander, NOS
14	Thai	98	Other
15	Asian Indian or Pakistani, NOS (formerly code 09)	99	Unknown
16	Asian Indian		
17	Pakistani		

Examples

Code	Reason
01	A patient was born in Mexico of Mexican parentage. Code also <i>Spanish/Hispanic Origin</i> (NAACCR Item #190).
02	A black female patient.
05	A patient has a Japanese father and a Caucasian mother. (Caucasian will be coded in <i>Race 2</i>).

Field 19) RACE 2

Item Length: 2

Allowable Values: 01-08, 10-17, 20-22, 25-28, 30-32, 88, 96-99

NAACCR Item #161

Source of Information: *FORDS: Revised for 2010*

Description

Identifies the primary race of the person.

Rationale

Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow for an accurate national comparison.

Instructions for Coding

- “Race” is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 1* (NAACCR Item #160) is coded 99, then *Race 2* must be coded 99.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- See the instructions for *Race 1* (NAACCR Item #160) for coding sequences for entering multiple races.

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorroan
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean
12	Hmong	88	No additional races
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS (formerly code 09)	98	Other
16	Asian Indian	99	Unknown
17	Pakistani		

Field 20) RACE 3

Item Length: 2

Allowable Values: 01-08, 10-17, 20-22, 25-28, 30-32, 88, 96-99

NAACCR Item #162

Source of Information: *FORDS: Revised for 2010*

Description

Identifies the primary race of the person.

Rationale

Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow for an accurate national comparison.

Instructions for Coding

- “Race” is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 2* (NAACCR Item #161) is coded 88 or 99, then *Race 3* must be coded with the same value.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- See the instructions for *Race 1* (NAACCR Item #160) for coding sequences for entering multiple races.

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorroan
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean
12	Hmong	88	No additional races
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS (formerly code 09)	98	Other
16	Asian Indian	99	Unknown
17	Pakistani		

Field 21) RACE 4

Item Length: 2

Allowable Values: 01-08, 10-17, 20-22, 25-28, 30-32, 88, 96-99

NAACCR Item #163

Source of Information: *FORDS: Revised for 2010*

Description

Identifies the primary race of the person.

Rationale

Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow for an accurate national comparison.

Instructions for Coding

- “Race” is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 3* (NAACCR Item #162) is coded 88 or 99, then *Race 4* must be coded with the same value.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- See the instructions for *Race 1* (NAACCR Item #160) for coding sequences for entering multiple races.

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorroan
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean
12	Hmong	88	No additional races
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS (formerly code 09)	98	Other
16	Asian Indian	99	Unknown
17	Pakistani		

Field 22) RACE 5

Item Length: 2

Allowable Values: 01-08, 10-17, 20-22, 25-28, 30-32, 88, 96-99

NAACCR Item #164

Source of Information: *FORDS: Revised for 2010*

Description

Identifies the primary race of the person.

Rationale

Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow for an accurate national comparison.

Instructions for Coding

- “Race” is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 4* (NAACCR Item #163) is coded 88 or 99, then *Race 5* must be coded with the same value.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- See the instructions for *Race 1* (NAACCR Item #160) for coding sequences for entering multiple races.

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorroan
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean
12	Hmong	88	No additional races
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS (formerly code 09)	98	Other
16	Asian Indian	99	Unknown
17	Pakistani		

Field 23) HISPANIC (Spanish/Hispanic Origin)	Item Length: 1 Allowable Values: 0-9 NAACCR Item #190 Source: <i>FORDS: Revised for 2010</i>
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Description

Identifies persons of Spanish or Hispanic origin.

Rationale

This code is used by hospital and central registries to identify whether or not the person should be classified as “Hispanic” for purposes of calculating cancer rates. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the 01 (White category) of *Race 1* through *Race 5* (NAACCR Item #s 160-164).

Instructions for Coding

- Persons of Spanish or Hispanic origin may be of any race, but these categories are generally not used for Native Americans, Filipinos, or others who may have Spanish names.
- Code 0 (Non-Spanish; non-Hispanic) for Portuguese and Brazilian persons.
- If the patient has multiple tumors, all records should have the same code.

Code	Label
0	Non-Spanish; non-Hispanic
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6	Spanish, NOS; Hispanic, NOS; Latino, NOS (There is evidence other than surname or maiden name that the person is Hispanic, but he/she cannot be assigned to any category of 1-5)
7	Spanish surname only (The only evidence of the person’s Hispanic origin is surname or maiden name, and there is no contrary evidence that the person is not Hispanic.)
8	Dominican Republic (for use with patients who were diagnosed with cancer on January 1, 2005, or later)
9	Unknown whether Spanish or not; not stated in patient record

Field 24) USUAL OCCUPATION (Text)

Item Length: 100

Allowable Values: Letters and Numbers

NAACCR Item #310

Source of Information: *NAACCR Data Dictionary, Version 12*

Description

Text area for information about the patient’s usual occupation, also known as usual type of job or work.

Rationale

Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies occupational groups in which cancer screening or prevention activities may be beneficial.

Instructions for Coding

Record the patient’s usual occupation (i.e., the kind of work performed during most of the patient’s working life before diagnosis of this tumor). Do not record “retired.” If usual occupation is not available or is unknown, record the patient’s current or most recent occupation, or any available occupation.

If later documentation in the patient’s record provides an occupation that is more likely to be the usual occupation than what was originally recorded, facility registrars are encouraged to update the case abstract with the new information. However, it is not the responsibility of the facility registrars to update abstracts with occupation information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

If the patient was a homemaker and also worked outside the home during most of his/her adult life, record the usual occupation outside the home; if the patient was a homemaker and did not work outside the home for most of his/her adult life, record “homemaker.” If the patient was not a student or homemaker and had never worked, record “never worked” as the usual occupation.

If no information is available, record “unknown.”

This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

Field 25) USUAL INDUSTRY (Text)

Item Length: 100

Allowable Values: Letters and Numbers

NAACCR Item #320

Source of Information: *NAACCR Data Dictionary, Version 12*

Description

Text area for information about the patient’s usual industry, also known as usual kind of business/industry.

Rationale

Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial.

Instructions for Coding

Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Be sure to distinguish among “manufacturing,” “wholesale,” “retail,” and “service” components of an industry that performs more than one of these components.

If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient for facility registrars to record the name of the company (with city or town) in which the patient performed his/her usual industry. In these situations, if resources permit, a central or regional registry may be able to use the employer name and city/town to determine the type of activity conducted at that location.

As noted in *Usual Occupation (Text)* (NAACCR Item #310) section, in those situations where the usual occupation is not available or is unknown, the patient’s current or most recent occupation is recorded, if available. The information for industry should be based upon the information in occupation. Therefore, if current or most recent occupation rather than usual occupation was recorded, record the patient’s current or most recent business/industry.

If later documentation in the patient’s record provides an industry that is more likely to be the usual industry than what was originally recorded, facility registrars are encouraged to update the abstract with the new information. However, it is not the responsibility of the facility registrars to update abstracts with industry information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

There should be an entry for *Usual Industry (Text)*, if any occupation is recorded. If no information is available regarding the industry in which the reported occupation was carried out, record “unknown.” If the patient was not a student or homemaker and had never worked, record “never worked” as the usual industry. This data item usually is collected only for patients who are 14 years or older at the time of diagnosis.

Field 26) TOBACCO HISTORY

Item Length: 1

Allowable Values: 0-5, 9

NAACCR Item #340

Source of Information: *OCISS*

Description

Identifies the patient's past or current use of tobacco.

Instructions for Coding

Code	Definition
0	Never used
1	Cigarette smoker, current
2	Cigar/pipe smoker, current
3	Snuff/chew/smokeless, current
4	Combination use, current
5	Previous use (no use within past year)
9	Unknown

Field 27) DATE OF DIAGNOSIS

Item Length: 8

NAACCR Item #390

Source of Information: *FORDS: Revised for 2010*

Description

Records the date of initial diagnosis by a physician for the tumor being reported.

Rationale

The timing for staging and treatment of cancer begins with the date of initial diagnosis for cancer.

Instructions for Coding

- Use the first date of diagnosis whether clinically or histologically established.
- If the physician states that in retrospect the patient had cancer at an earlier date, then use the earlier date as the date of diagnosis.
- Use the date treatment was started as the date of diagnosis if the patient receives a first course of treatment before a definitive diagnosis.
- Refer to the list of “Ambiguous Terms at Diagnosis” in *FORDS: Revised for 2010*, Section One for language that represents a diagnosis of cancer.
- The date of death is the date of diagnosis for a *Class of Case* (NAACCR Item #610) 38 (diagnosed at autopsy) or 49 (death certificate only).
- Use the actual date of diagnosis for an *in utero* diagnosis, for cases diagnosed on January 1, 2009, or later.
- If the year of diagnosis cannot be identified, it must be approximated. In that instance, the month and day are unknown.

Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Initial Diagnosis* MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Initial Diagnosis* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date.

Field 28) PRIMARY SITE

Item Length: 4

Allowable Values: See *International Classification of Diseases for Oncology, Third Edition, (ICD-O-3)*

NAACCR Item #400

Source of Information: *FORDS: Revised for 2010*

Description

Identifies the primary site.

Rationale

Primary site is a basis for staging and the determination of treatment options. It also affects the prognosis and course of the disease.

Instructions for Coding

- Record the ICD-O-3 topography code for the site of origin.
- Consult the physician advisor to identify the primary site or the most definitive site code if the medical record does not contain that information.
- Topography codes are indicated by a “C” preceding the three-digit code number. Do not record the decimal point.
- Follow the Instructions for Coding in ICD-O-3, pages 20–40 and in the current *SEER Multiple Primary and Histology Coding Rules* to assign site for solid tumors.
- Follow the instructions in *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the Hematopoietic and Lymphoid Neoplasms Database (Hematopoietic DB) for assigning site for lymphomas, leukemia and other hematopoietic neoplasms.
- Use subcategory 8 for single tumors that overlap the boundaries of two or more sub-sites and the point of origin is not known.
- Use subcategory 9 for multiple tumors that originate in different subsites of one organ.

Examples

Code	Reason
C108	Overlapping lesion of oropharynx. Code overlapping lesion when a large tumor involves both the lateral wall of the oropharynx (C10.2) and the posterior wall of the oropharynx (C10.3) and the point of origin is not stated.
C678	Overlapping lesion of bladder. Code overlapping lesion of the bladder when a single lesion involves the dome (C67.1) and the lateral wall (C67.2) and the point of origin is not stated.
C189	Colon, NOS. Familial polyposis with carcinoma and carcinoma in situ throughout the transverse (C18.4) and descending colon (C18.6) would be one primary and coded to colon, NOS (C18.9). For a full explanation see the <i>SEER 2007 Multiple Primary and Histology Coding Rules</i> .
C16-	Stomach (sub-site as identified). An extranodal lymphoma of the stomach is coded to C16.– (sub-site as identified).

Field 29) LATERALITY AT DIAGNOSIS

Item Length: 1
 Allowable Values: 0-5, 9
 NAACCR Item #410
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies the side of a paired organ or the side of the body on which the reportable tumor originated. This applies to the primary site only.

Rationale

Laterality supplements staging and extent of disease information and defines the number of primaries involved.

Instructions for Coding

- Code laterality for all paired sites. (See List of Paired Organ Sites below.)
- Do not code metastatic sites as bilateral involvement.
- Where the right and left sides of paired sites are contiguous (come into contact) and the lesion is at the point of contact of the right and left sides, use code 5, midline. Note that “midline of the right breast” is coded 1, right; midline in this usage indicates the primary site is C50.8 (overlapping sites).
- Non-paired sites may be coded right or left, if appropriate. Otherwise, code non-paired sites 0.

Code	Definition
0	Organ is not a paired site.
1	Origin of primary is right.
2	Origin of primary is left.
3	Only one side involved, right or left origin not specified.
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms tumors
5	Paired site: midline tumor
9	Paired site, but no information concerning laterality

List of Paired Organ Sites

ICD-O-3	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)
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)
C34.1-C34.9	Lung
C38.4	Pleura
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)
C41.4	Pelvic bones (excluding sacrum, coccyx, and symphysis pubis)
C44.1	Skin of eyelid

ICD-O-3	Site
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face
C44.5	Skin of trunk
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb 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 tissues of upper limb and shoulder
C49.2	Connective, subcutaneous, and other soft tissues of lower limb and hip
C50.0-C50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube
C62.0-C62.9	Testis
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0-C69.9	Eye and lacrimal gland
C70.0	Cerebral meninges, NOS (excluding diagnoses prior to 2004)
C71.0	Cerebrum (excluding diagnoses prior to 2004)
C71.1	Frontal lobe (excluding diagnoses prior to 2004)
C71.2	Temporal lobe (excluding diagnoses prior to 2004)
C71.3	Parietal lobe (excluding diagnoses prior to 2004)
C71.4	Occipital lobe (excluding diagnoses prior to 2004)
C72.2	Olfactory nerve (excluding diagnoses prior to 2004)
C72.3	Optic nerve (excluding diagnoses prior to 2004)
C72.4	Acoustic nerve (excluding diagnoses prior to 2004)
C72.5	Cranial nerve, NOS (excluding diagnoses prior to 2004)
C74.0-C74.9	Adrenal gland
C75.4	Carotid body

Field 30) PRIMARY SITE SUBSTANTIATING TEXT

Item Length: 100
 Allowable Values: Letters and Numbers
 NAACCR Item #2580
 Source of Information: *NAACCR Data Dictionary, Version 12*

Description

Text area for manual documentation of information regarding the primary site and laterality of the tumor being reported.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Instructions for Coding

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See Appendix 8 of this manual).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- State the specific location of the primary site, including subsite.
- Include available information on tumor laterality.

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

OCISS Field Number	OCISS Field Name	NAACCR Item Number
Field 28	Primary Site	400
Field 29	Laterality at Diagnosis	410

Field 31) HISTOLOGY/BEHAVIOR

Item Length: 4/1

Allowable Values: See *International Classification of Diseases for Oncology, Third Edition, (ICD-O-3)*

NAACCR Item #522/#523

Source of Information: *FORDS: Revised for 2010/OCISS*

HISTOLOGY

Description

Identifies the microscopic anatomy of cells.

Rationale

Histology is a basis for staging and the determination of treatment options. It also affects the prognosis and course of the disease.

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).
- ICD-O-3 identifies the morphology codes with an “M” preceding the code number. Do not record the “M.”
- Follow the coding rules outlined on pages 20 through 40 of ICD-O-3.
- Use the *SEER Multiple Primary and Histology Coding Rules* when coding the histology for all 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 January 1, 2007.
- 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, 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).
- Lymphomas may be classified by the Rappaport classification or the Working Formulation. If both systems are used to classify the disease, then the term used to describe the lymphoma may differ. The Working Formulation term should take precedence (ICD-O-3, pp. 13-18).

Examples

Code	Label	Reason
8140	Adenocarcinoma	Final pathologic diagnosis is carcinoma, NOS (8010) of the prostate. Microscopic diagnosis specifies adenocarcinoma (8140) of the prostate.
9680	Diffuse large B-cell lymphoma	Diffuse large B-cell lymphoma, per the WHO Classification of Hematopoietic and Lymphoid Neoplasms.

BEHAVIOR

Description

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

Rationale

The behavior code is used by pathologists to describe whether tissue samples are benign (0), borderline (1), in situ (2), or malignant (3).

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.

Note: The ICD-O-3 behavior code for juvenile astrocytoma (9421/1) is coded as 3. (See “Case Eligibility” in FORDS: Revised for 2010, Section One, for more information.)

Code	Label	Definition
0	Benign	Benign
1	Borderline	Uncertain whether benign or malignant.
		Borderline malignancy.
		Low malignant potential.
		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.
		Noninvasive.
		No stromal involvement.
		Papillary, noninfiltrating or intraductal.
		Precancerous melanosis (C44._).
Queyrat erythroplasia (C60._).		
3	Invasive	Invasive or microinvasive.

Example

Code	Reason
3	Intraductal carcinoma (8500/2) with focal areas of invasion.

Field 32) HISTOLOGY/BEHAVIOR SUBSTANTIATING TEXT

Item Length: 100
 Allowable Values: Letters and Numbers
 NAACCR Item #2590
 Source of Information: *NAACCR Data Dictionary, Version 12*

Description

Text area for manual documentation of information regarding the histologic type, behavior, and grade (differentiation) of the tumor being reported.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Instructions for Coding

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See Appendix 8 of this manual).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Information on histologic type and behavior
- Information on differentiation from scoring systems such as Gleason’s Score, Bloom-Richardson Grade, etc.

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

OCISS Field Number	OCISS Field Name	NAACCR Item Number
Field 31	Histology/Behavior	522
Field 31	Histology/Behavior	523
Field 33	Grade	440

Field 33) GRADE (DIFFERENTIATION) Item Length: 1
 Allowable Values: 1-9
 NAACCR Item #440
 Source of Information: *FORDS: Revised for 2010*

Description
 Describes the tumor’s resemblance to normal tissue. Well differentiated (Grade 1) is the most like normal tissue, and undifferentiated (Grade 4) is the least like normal tissue. Grades 5–8 define particular cell lines for lymphomas and leukemias.

Rationale
 This data item is useful for prognosis.

Instructions for Coding

- Code grade according to ICD-O-3 (pp. 30–31 and 67).
- 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.
- When the pathology report(s) lists more than one grade of tumor, code to the highest grade, even if the highest grade is only a focus (Rule G, ICD-O-3, p. 21).
- Code the grade or differentiation from the pathologic examination of the primary tumor, not from metastatic sites.
- When there is no tissue diagnosis, it may be possible to establish grade through magnetic resonance imaging (MRI) or positron emission tomography (PET). When available, code grade based on the recorded findings from these imaging reports.
- If the primary site is unknown, code *Grade/Differentiation* as 9 (Unknown).
- Code the grade for in situ lesions if the information is available. If the lesion is both invasive and in situ, code only the invasive portion. If the invasive component grade is unknown, then code 9.
- **Do not** use “high grade,” “low grade” or “intermediate grade” descriptions for lymphomas as a basis for differentiation. These terms are categories in the Working Formulation of Lymphoma Diagnoses and do not relate to *Grade/Differentiation*.
- Codes 5–8 define T-cell or B-cell origin for leukemias and lymphomas. T-cell, B-cell, or null cell classifications have precedence over grading or differentiation.
- Do not use the WHO grade to code this data item.
- If no grade is given for astrocytomas, code 9 (Unknown).
- If no grade is given for glioblastoma multiforme, code 9 (Unknown).
- See *FORDS: Revised for 2010* Section I to convert other solid tumor grade systems to *Grade/Differentiation*.
- If *Grade Path System* (NAACCR Item #449) and *Grade Path Value* (NAACCR Item #441) are coded, *Grade/Differentiation* (NAACCR Item #440) must not be 9.

Code	Grade/Cell	Description
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-precursor
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 (adenocarcinoma in situ)

Field 33a) GRADE PATH SYSTEM

Item Length: 1
 Allowable Values: 2-4, Blank
 NAACCR Item #449
 Source of Information: *FORDS: Revised for 2010*

Description

Indicates whether a two, three or four grade system was used in the pathology report.

Rationale

This item is used to show whether a two, three or four grade system was used in the pathology report to describe the grade. This item is used in conjunction with *Grade Path Value* (NAACCR Item #441).

Instructions for Coding

- This item may be left blank for cases diagnosed prior to 2010.
- Code this item from the same tissue as that used to code *Grade/Differentiation* (NAACCR Item #440).
- Code the value corresponding to the number of grades used in the grading system reported in the pathology report.
- Leave the item blank if no pathologic grade is available.
- Leave the item blank if only a verbal description of grade is reported (for example, 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, Fuhman 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* (NAACCR Item #441) should both be coded or both be blank. If both are coded, *Grade/Differentiation* (NAACCR Item #440) must not be 9.

Code	Definition
Blank	No 2, 3 or 4 grade system available. Unknown.
2	A 2-grade grading system was used (2, II or ii)
3	A 3-grade grading system was used (3, III or iii)
4	A 4-grade grading system was used (4, IV or iv)

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 at all in the pathology report

Field 33b) GRADE PATH VALUE

Item Length: 1
 Allowable Values: 1-4, Blank
 NAACCR Item #441
 Source of Information: *FORDS: Revised for 2010*

Description

Describes the grade assigned according to the grading system in *Grade Path System* (NAACCR Item #449).

Rationale

This item records the numeric grade reported in the pathology report. This item supplements but does not replace *Grade/Differentiation* (NAACCR Item #440).

Instructions for Coding

- This item may be left blank for cases diagnosed prior to 2010.
- Code this item from the same tissue as that used to code *Grade/Differentiation* (NAACCR Item #440). This item records how the original grade of the tumor was described.
- Code the value of the numeric grade from the pathology report if the *Grade Path System* (NAACCR Item #449) was 2-4. 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 that is all that is available.
- Leave the item blank if a numeric grade is given, but the grading system is not stated (for example, Grade 1, with no information about the grade system).
- 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, Fuhman 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* (NAACCR Item #441) should both be coded or both be blank. If both are coded, *Grade/Differentiation* (NAACCR Item #440) must not be 9. *Grade Path Value* can never be larger than *Grade Path System*.

Code	Definition
Blank	No 2-, 3- or 4-grade system available. Unknown.
1	Recorded as Grade I, i or 1 of a 2-4 grade system
2	Recorded as Grade II, ii or 2 of a 2-4 grade system
3	Recorded as Grade III, iii or 3 of a 3-4 grade system
4	Recorded as Grade IV, iv or 4 of a 4 grade system

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 at all in the pathology report
Blank	The pathology report indicates that the grade is 2, but no mention of the system is made

Field 34) DIAGNOSTIC CONFIRMATION

Item Length: 1
 Allowable Values: 1-9
 NAACCR Item #490
 Source of Information: *FORDS: Revised for 2010*

Description

Records the best method of diagnostic confirmation of the cancer being reported at any time in the patient’s history.

Rationale

This item is an indicator of the precision of diagnosis. The percentage of solid tumors that are clinically diagnosed only is an indication of whether casefinding is including sources outside of pathology reports. Full incidence calculations must include both clinically and pathologically confirmed cases.

Instructions for Coding Solid tumors (all tumors except M9590-9992)

- 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 data item must be changed to the lower (higher priority) code if a more definitive method confirms the diagnosis *at any time during* the course of the disease.
- Assign code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, autopsy of D&C or from aspiration of biopsy of bone marrow specimens.
- Assign code 2 when the microscopic diagnosis is based on cytologic examination of *cells* such as sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.
- Code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer.
- Code 6 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.

Codes for Solid Tumors

Code	Label	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined).
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer. Examples include alpha-fetoprotein for liver cancer and abnormal electrophoretic spike for multiple myeloma. Elevated PSA is not diagnostic of cancer. If the physician uses the PSA as a basis for diagnosing prostate cancer with no other workup, record as code 5.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.
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, other than 5, 6, or 7	The malignancy was reported by the physician in the medical record.
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 (usually nonanalytic).

Instructions for Coding Hematopoietic or Lymphoid Tumors (9590-9992)

- There is no priority hierarchy or coding Diagnostic Confirmation for hematopoietic and lymphoid tumors. Most commonly, the specific histologic type is diagnosed by immunophenotyping or genetic testing. See the *Hematopoietic Database (DB)* for information on the definitive diagnostic confirmation for specific types of tumors.
- Code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, or autopsy or bone marrow specimens from aspiration or biopsy.
- For leukemia only, code 1 when the diagnosis is based on the complete blood count (CBC), white blood count (WBC) or peripheral blood smear. Do not use code 1 if the diagnosis was based on immunophenotyping or genetic testing using tissue, bone marrow, or blood.
- Use code 2 when the microscopic diagnosis is based on cytologic examination of *cells* (rather than tissue) including but not limited to spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. These methods are rarely used for hematopoietic or lymphoid tumors.
- Assign code 3 when there is a histology positive for cancer AND positive immunophenotyping and/or positive genetic testing results. Do not use code 3 for neoplasms diagnosed prior to January 1, 2010.
- Assign code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer, but no positive histologic confirmation.
- Assign code 6 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.
- Assign code 8 when the case was diagnosed by any clinical method that cannot be coded as 6 or 7. 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.

Codes for Hematopoietic and Lymphoid Neoplasms

Code	Label	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined).
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
3	Positive histology PLUS <ul style="list-style-type: none"> • Positive immunophenotyping AND/OR • Positive genetic studies 	Histology is positive for cancer, and there are also positive immunophenotyping and/or genetic test results. For example, bone marrow examination is positive for acute myeloid leukemia. (9861/3) Genetic testing shows AML with inv (16) (p.13.1q22) (9871/3).
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
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.
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 other than 5, 6, or 7	The malignancy was reported by the physician in the medical record.
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 (usually nonanalytic).

Field 35) VITAL STATUS

Item Length: 1

Allowable Values: 0, 1

NAACCR Item #1760

Source of Information: *FORDS: Revised for 2010*

Description

Records the vital status of the patient as of the date entered in *Date of Last Contact or Death* (NAACCR Item #1750).

Rationale

This information is used for patient follow-up and outcomes studies.

Instructions for Coding

- This item is collected during the follow-up process with *Date of Last Contact or Death* (NAACCR Item #1750).
- If a patient has multiple primaries, all records should have the same vital status.

Code	Label
0	Dead
1	Alive

Examples

Code	Reason
0	Death clearance information obtained from a state central registry confirms the death of the patient within the past year.
1	In response to a follow-up letter to a patient's following physician, it is learned the patient is alive.

Field 36) DATE OF LAST CONTACT OR DEATH (at this Facility)

Item Length: 8

NAACCR Item #1750

Source of Information: *FORDS: Revised for 2010*

Description

Records the date of last contact with the patient or the date of death.

Rationale

This information is used for patient follow-up and outcomes studies.

Instructions for Coding

- Record the last date on which the patient was known to be alive or the date of death.
- If a patient has multiple primaries, all records should have the same date of last contact.
- As of January 1, 2006, the CoC does not require *Class of Case 00* cases to be followed.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Last Contact or Death* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Last Contact or Death* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date of Last Contact Flag* (NAACCR Item #1751) is used to explain why *Date of Last Contact or Death* is not a known date. See *Date of Last Contact Flag* for an illustration of the relationships among these items.

Field 37) CAUSE OF DEATH

Field 38) PLACE OF DEATH

Data fields no longer collected, effective with cases diagnosed on or after January 1, 2010.

These data fields will be populated by OCISS from death certificates.

Field 39) SEQUENCE NUMBER

Item Length: 2
 Allowable Values: 00-88, 99
 NAACCR Item #560
 Source of Information: *FORDS: Revised for 2010*

Description

Indicates the sequence of malignant and nonmalignant neoplasms over the lifetime of the patient.

Rationale

This data item is used to distinguish among cases having the same accession numbers, to select patients with only one malignant primary tumor for certain follow-up studies, and to analyze factors involved in the development of multiple tumors.

Instructions for Coding

- Codes 00-59 and 99 indicate neoplasms of *in situ* or malignant behavior (*Behavior* equals 2 or 3). Codes 60-88 indicate neoplasms of non-malignant behavior (*Behavior* equals 0 or 1).
- Code 00 only if the patient has a single malignant primary. If the patient develops a subsequent malignant or *in situ* primary tumor, change the code for the first tumor from 00 to 01, and number subsequent tumors sequentially.
- Code 60 only if the patient has a single nonmalignant primary. If the patient develops a subsequent non-malignant primary, change the code for the first tumor from 60 to 61, and assign codes to subsequent non-malignant primaries sequentially.
- If two or more malignant or *in situ* neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
- Any tumor in the patient’s past which is reportable or reportable-by-agreement at the time the current tumor is diagnosed must be taken into account when sequencing subsequently accessioned tumors. However, do not reassign sequence numbers if one of those tumors becomes nonreportable later.
- Sequence numbers should be reassigned if the facility learns later of an unaccessioned tumor that affects the sequence.

Malignant or In Situ Primaries

Code	Definition
00	One primary or <i>in situ</i> primary only in the patient’s lifetime
01	First of two or more independent malignant or <i>in situ</i> primaries
02	Second of two or more independent malignant or <i>in situ</i> primaries
...	
...	(Actual sequence of this malignant or <i>in situ</i> primary)
...	
59	Fifty-nine of 59 or more independent malignant or <i>in situ</i> primaries
99	Unknown number of malignant or <i>in situ</i> primaries

Non-Malignant Primaries

Code	Definition
60	One non-malignant primary only in the patient’s lifetime
61	First of two or more independent nonmalignant primaries
62	Second of two or more independent nonmalignant primaries
...	
...	(Actual sequence of this nonmalignant primary)
...	
87	Twenty-seventh of 27 or more independent nonmalignant primaries
88	Unspecified number of independent nonmalignant primaries

Examples

Code	Reason
00	Patient with no previous history of cancer diagnosed with <i>in situ</i> breast carcinoma on June 13, 2003.
01	The sequence number is changed when the patient with an <i>in situ</i> breast carcinoma diagnosed June 13, 2003, is diagnosed with a subsequent melanoma on August 30, 2003.
02	Sequence number assigned to the melanoma diagnosed on August 30, 2003, following a breast cancer <i>in situ</i> diagnosis on June 13, 2003.
04	A nursing home patient is admitted to the hospital for first course surgery for a colon adenocarcinoma. The patient has a prior history of three malignant cancers of the type the registry is required to accession, though the patient was not seen for these cancers at the hospital. No sequence numbers 01, 02 or 03 are accessioned for this patient.
60	The sequence number assigned to a benign brain tumor diagnosed on November 1, 2005, following a breast carcinoma diagnosed on June 13, 2003, and a melanoma on August 30, 2003.
63	Myeloproliferative disease (9975/1) is diagnosed by the facility in 2003 and accessioned as Sequence 60. A benign brain tumor was diagnosed and treated elsewhere in 2002; the patient comes to the facility with a second independent benign brain tumor in 2004. Unaccessioned earlier brain tumor is counted as Sequence 61, myeloproliferative disease is resequenced to 62, and second benign brain tumor is Sequence 63.

Field 40) DATE OF FIRST CONTACT (at this Facility)

Item Length: 8

NAACCR Item #580

Source of Information: *FORDS: Revised for 2010*

Description

Date of first contact with the reporting facility for diagnosis and/or treatment of this cancer.

Rationale

This data item can be used to measure the time between first contact and the date that the case was abstracted. It can also be used to measure the length of time between the first contact and treatment for quality of care reports.

Instructions for Coding

- Record the date the patient first had contact with the facility as either an inpatient or outpatient for 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-only 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.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of First Contact* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of First Contact* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date. The *Date of First Contact Flag* (NAACCR Item #581) is used to explain why *Date of First Contact* is not a known date. See *Date of First Contact Flag* for an illustration of the relationships among these items.

Examples

Code	Reason
February 12, 2008	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.
September 14, 2009	Patient undergoes a biopsy in a physician’s office on September 8, 2009. The pathology specimen was sent to the reporting facility and was read as malignant melanoma. The patient enters that same reporting facility on September 14, 2009 for wide reexcision.
December 7, 2010	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.
April 2003	Information is limited to the description “Spring,” 2003.
July 2003	Information is limited to the description “The middle of the year,” 2003.
October 2003	Information is limited to the description “Fall,” 2003.
December or January	If information is limited to the description “Winter,” try to determine if this means the beginning or the end of the year.

Field 41) CLASS OF CASE

Item Length: 2

Allowable Values: 00, 10-14, 20-22, 30-38, 40-43, 49, 99

NAACCR Data Item: 610

Source of Information: *FORDS: Revised for 2010*

Description

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. Analytic cases are grouped according to the location of diagnosis and first course of treatment. 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. Nonanalytic cases are grouped according to the reason a patient who received care at the facility is nonanalytic, or the reason a patient who never received care at the facility may have been abstracted.

Rationale

Class of Case reflects the facility’s role in managing the cancer, whether the cancer is required to be reported by CoC, and whether the case was diagnosed after the program’s Reference Date.

Instructions for Coding

- The code structure for this item was revised in 2010. See *NAACCR Inc. 2010 Implementation Guidelines and Recommendations* for conversion instructions between code structures.
- Code the *Class of Case* that most precisely describes the patient’s relationship to the facility.
- Code 00 applies only when it is known 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, change the code accordingly.
- Document *Facility Referred To* and NPI–Facility Referred To (NAACCR Item #s 2420 and 2425) or the applicable physician NPI (NAACCR #s 2585, 2495, 2505) for patients coded 00 to establish that the patient went elsewhere for treatment.
- Code 34 or 36 if the diagnosis benign or borderline (*Behavior* 0 or 1) for any site diagnosed before 2004 or for any site other than meninges (C70._), brain (C71._), spinal cord, cranial nerves, and other parts of central nervous system (C72._), pituitary gland (C75.1), craniopharyngeal duct (C75.2) and pineal gland (C75.3) that were diagnosed in 2004 or later.
- Code 34 or 36 for carcinoma in situ of the cervix (CIS) and intraepithelial neoplasia grade III (8077/2 or 8148/2) of the cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III).
- A staff physician (codes 10-12, 41) is a physician who is employed by the reporting facility, under contract with it, or a physician who has routine practice privileges there.

Codes

Analytic Classes of Case (Required by CoC to be abstracted by accredited programs)	
	<i>Initial diagnosis at reporting facility</i>
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 a 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
	<i>Initial diagnosis elsewhere</i>
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

Classes of Case NOT required by CoC to be abstracted (May be required by Cancer Committee, state or regional registry, or other entity)	
	<i>Patient appears in person at reporting facility</i>
30	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, staging workup after initial diagnosis elsewhere)
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 patient 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 (for example, a benign colon tumor) 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 (for example, a benign colon tumor) 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
	<i>Patient does not appear in person at reporting facility</i>
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 (for example, hospital abstracts cases from an independent radiation facility)
43	Pathology or other lab specimens only
49	Death certificate only
99	Nonanalytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases).

Examples

Code	Reason
32	After treatment failure, the patient was admitted to the facility for supportive care
11	Patient was diagnosed by a staff physician, received radiation at another facility, then underwent surgical resection at the reporting facility
42	Patients from an unaffiliated, free-standing clinic across the street that hospital abstracts with its cases because many physicians work both at the clinic and the hospital.

Field 41a) DIAGNOSTIC PROCEDURE CODE Item Length: 2
 Allowable Values: 00-07, 09
 NAACCR Data Item: 1350
 Source of Information: *FORDS: Revised for 2010*

Description
 Identifies the surgical procedure (s) performed in an effort to diagnose and/or stage disease.

Rationale
 This data item is used to track the use of surgical procedure resources that are not considered treatment.

Instructions for Coding

- 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).
- If a lymph node is biopsied or removed to diagnose or stage *lymphoma*, and that node is NOT the only node involved with lymphoma, use code 02. If there is only a single lymph node involved with lymphoma, use the data item *Surgical Procedure of Primary Site* (NAACCR Item #1290) to code these procedures.
- 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* (NAACCR Item #1292) to code these procedures. Do not record the date of surgical procedures which aspirate, biopsy, or remove regional lymph nodes in the data item *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280). See instructions for *Scope of Regional Lymph Node Surgery* (NAACCR Item # 1292).
- Code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item *Diagnostic Confirmation* (NAACCR Item #490). These are not considered surgical procedures and should not be coded in this item.
- Do not code excisional biopsies with clear or microscopic margins in this data item. Use the data item *Surgical Procedure of Primary Site* (NAACCR Item #1290) to code these procedures.
- Do not code palliative surgical procedures in this data item. Use the data item *Palliative Procedure* (NAACCR Item #3270) to code these procedures.

Code	Definition
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 exploratory 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 of whether a diagnostic or staging procedure was performed.

Examples

Code	Reason
00	A lung cancer primary was diagnosed by CT scan. The patient expired. No surgical diagnostic or staging surgical procedure was performed.
00	A sputum sample is examined cytologically to confirm a diagnosis of suspected lung cancer. The procedure is not surgical.
01	A needle biopsy of a liver metastasis in a patient with suspected widespread colon cancer was done. Gross residual tumor is left at the biopsy site.
03	During abdominal exploratory surgery, a gastric lesion and suspicious retroperitoneal lymph nodes were observed. No biopsy or treatment was done.
04	An abdominal exploration of a patient revealed pancreatic carcinoma with extension into surrounding organs and arteries. No attempt to treat. A bypass was performed to alleviate symptoms.
05	An exploratory procedure was performed for primary colon carcinoma with biopsy of suspicious liver lesions.
06	Esophagogastrectomy was performed for infiltrating gastric tumor following a biopsy of the primary site.
07	Stage III lung carcinoma was diagnosed and staged prior to admission.
09	A patient expires in the emergency room with recently diagnosed metastatic melanoma. It is unknown whether a diagnostic or staging procedure was done.

Field 41b) DATE OF DIAGNOSTIC PROCEDURE

Item Length: 8

NAACCR Data Item: 1280

Source of Information: *FORDS: Revised for 2010*

Description

Records the date on which the surgical diagnostic and/or staging procedure was performed.

Rationale

This data item is used to track the used of surgical procedure resources that are not considered treatment.

Instructions for Coding

- Record the date on which the surgical diagnostic and/or staging procedure described in *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350) was performed at this or any facility.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Surgical Diagnostic and Staging Procedure* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Surgical Diagnostic and Staging Procedure* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date-DX/Stg Proc Flag* (NAACCR Item #1281) is used to explain why *Date of Surgical Diagnostic and Staging Procedure* is not a known date. See *RX Date-DX/Stg Proc Flag* for an illustration of the relationships among these items.

Field 41c) DATE OF DIAGNOSTIC PROCEDURE FLAG

Item Length: 2
 Allowable Values: 10-12, Blank
 NAACCR Data Item: 1281
 Source of Information: *FORDS: Revised for 2010*

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280).

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Instructions for Coding

- Leave this item blank if *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280) has a full or partial date recorded.
- Code 10 if it is unknown whether a surgical diagnostic or staging procedure was performed.
- Code 11 if no surgical diagnostic or staging procedure was performed.
- Code 12 if the *Date of Surgical Diagnostic and Staging Procedure* cannot be determined, but a surgical diagnostic or staging procedure was performed for the patient.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any diagnostic or staging procedure performed).
11	No proper value is applicable in this context (for example, no diagnostic or staging procedure performed; autopsy only case)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, diagnostic or staging procedure performed but date is unknown).
(blank)	A valid date value is provided in item <i>Date of Surgical Diagnostic and Staging Procedure</i> (NAACCR Item #1280). Case was diagnosed prior to January 1, 2007.

Field 42) PHYSICAL EXAM / OTHER CANCERS TEXT

Item Length: 1000

Allowable Values: Letters and Numbers

NAACCR Item #2520

Source of Information: *NAACCR Data Dictionary, Version 12*

Description

Text area for manual documentation from the history and physical examination about the history of the current tumor and the clinical description of the tumor.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should be generated electronically from coded values.

Instructions for Coding

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See Appendix 8 of this manual).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date of physical exam
- Age, sex, race/ethnicity
- History that relates to cancer diagnosis
- Primary site
- Histology (if diagnosis prior to this admission)
- Tumor location
- Tumor size
- Palpable lymph nodes
- Record positive and negative clinical findings. Record positive results first
- Impression (when stated and pertains to cancer diagnosis)
- Treatment plan

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

OCISS Field Number	OCISS Field Name	NAACCR Item Number
Field 40	Date of First Contact (at this Facility)	580
Field 7	Date of Diagnosis	390
Not collected by OCISS	Age at Diagnosis	230
Fields 19 - 23	Race 1 - Race 5	160 - 164
Field 24	Hispanic (Spanish/Hispanic Origin)	190
Field 12	Sex	220
Field 28	Primary Site	400
Field 30	Laterality at Diagnosis	410
Field 31	Histology /Behavior	522
Not collected by OCISS	Sequence Number -- Hospital	560
Fields 85-99	Collaborative Stage Variables	2800 - 2930
Field 100	SEER Summary Stage 1977	760
Field 100	SEER Summary Stage 2000	759

Field 43) X-RAY/SCANS TEXT

Item Length: 1000

Allowable Values: Letters and Numbers

NAACCR Item #2530

Source of Information: *NAACCR Data Dictionary, Version 12***Description**

Text area for manual documentation from all X-rays, scan, and/or other imaging examinations that provide information about staging.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should be generated electronically from coded values.

Instructions for Coding

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See Appendix 8 of this manual).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date(s) and type(s) of X-ray/Scan(s)
- Primary site
- Histology (if given)
- Tumor location
- Tumor size
- Lymph nodes
- Record positive and negative clinical findings. Record positive results first
- Distant disease or metastasis

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

OCISS Field Number	OCISS Field Name	NAACCR Item Number
Field 7	Date of Diagnosis	390
Field 41a	RX Summ – DX/Stg Proc	1350
Field 28	Primary Site	400
Field 30	Laterality at Diagnosis	410
Field 31	Histology/Behavior	522
Fields 85-99	Collaborative Stage Variables	2800 - 2930
Field 100	SEER Summary Stage 1977	760
Field 100	SEER Summary Stage 2000	759

Field 44) ENDOSCOPIC TEXT

Item Length: 1000

Allowable Values: Letters and Numbers

NAACCR Item #2540

Source of Information: *NAACCR Data Dictionary, Version 12***Description**

Text area for manual documentation from endoscopic examinations that provide information for staging and treatment.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should be generated electronically from coded values.

Instructions for Coding

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See Appendix 8 of this manual).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date(s) of endoscopic exam(s)
- Primary site
- Histology (if given)
- Tumor location
- Tumor size
- Record site and type of endoscopic biopsy
- Record positive and negative clinical findings. Record positive results first.

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

OCISS Field Number	OCISS Field Name	NAACCR Item Number
Field 7	Date of Diagnosis	390
Field 41a	RX Summ – DX/Stg Proc	1350
Field 34	Diagnostic Confirmation	490
Field 28	Primary Site	400
Field 30	Laterality at Diagnosis	410
Field 31	Histology /Behavior	522
Fields 85-99	Collaborative Stage Variables	2800 - 2930
Field 100	SEER Summary Stage 1977	760
Field 100	SEER Summary Stage 2000	759
Not collected by OCISS	RX Hosp – Surg Prim Site	670
Field 50	RX Date – Surgery Date	1200

Field 45) LABORATORY TEXT	Item Length: 1000 Allowable Values: Letters and Numbers NAACCR Item #2550 Source of Information: <i>NAACCR Data Dictionary, Version 12</i>
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Description

Text area for manual documentation on information from laboratory examinations other than cytology or histopathology.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should be generated electronically from coded values.

Instructions for Coding

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See Appendix 8 of this manual).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Type of lab test/tissue specimen(s)
- Record both positive and negative findings. Record positive results first.
- Information can include tumor markers, serum and urine electrophoresis, special studies, etc.
- Date(s) of lab test(s)
- Tumor markers included, but are not limited to:
 - Breast Cancer -- Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu
 - Prostate Cancer -- Prostatic Specific Antigen (PSA)
 - Testicular Cancer -- Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH)

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

OCISS Field Number	OCISS Field Name	NAACCR Item Number
Field 28	Primary Site	400
Field 33	Grade (Differentiation)	440
Field 34	Diagnostic Confirmation	490
Fields 85-99	Collaborative Stage Variables	2800 - 2930
Field 7	Date of Diagnosis	390

Field 46) SURGICAL TEXT (TEXT—DX PROC—OP)

Item Length: 1000

Allowable Values: Letters and Numbers

NAACCR Item #2560

Source of Information: *NAACCR Data Dictionary, Version 12*

Description

Text area for manual documentation of all surgical procedures that provide information for staging.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should be generated electronically from coded values.

Instructions for Coding

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See Appendix 8 of this manual).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived
- Number of lymph nodes removed
- Size of tumor removed
- Documentation of residual tumor
- Evidence of invasion of surrounding areas
- Reason why primary site surgery could not be completed

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

OCISS Field Number	OCISS Field Name	NAACCR Item Number
Field 7	Date of Diagnosis	390
Field 41a	RX Summ—DX/Stg Proc	1350
Field 34	Diagnostic Confirmation	490
Field 28	Primary Site	400
Not collected by OCISS	RX Hosp—DX/Stg Proc	740
Field 49	Surgery Code	1290
Fields 85 - 99	Collaborative Stage Variables	2800 - 2930
Field 100	SEER Summary Stage 1977	760
Field 100	SEER Summary Stage 2000	759
Field 74	Reason for No Surgery	1340

Field 47) PATHOLOGY TEXT

Item Length: 1000

Allowable Values: Letters and Numbers

NAACCR Item #2570

Source of Information: *NAACCR Data Dictionary, Version 12*

Description

Text area for manual documentation of information from cytology and histopathology reports.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should be generated electronically from coded values.

Instructions for Coding

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See Appendix 8 of this manual).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date(s) of procedure(s)
- Anatomic source of specimen(s)
- Type of tissue specimen(s)
- Tumor type and grade (include all modifying adjectives, i.e., predominantly, with features of, with foci of, elements of, etc.)
- Gross tumor size
- Extent of tumor spread
- Involvement of resection margins
- Number of lymph nodes involved and examined
- Record both positive and negative findings. Record positive test results first.
- Note if pathology report is a slide review or a second opinion from an outside source, i.e., AFIP, Mayo, etc.
- Record any additional comments from the pathologist, including differential diagnoses considered and any ruled out or favored.

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

OCISS Field Number	OCISS Field Name	NAACCR Item Number
Field 7	Date of Diagnosis	390
Field 28	Primary Site	400
Field 30	Laterality at Diagnosis	410
Field 31	Histology /Behavior	522
Field 33	Grade/Differentiation	440
Fields 85 - 99	Collaborative Stage Variables	2800 - 2930
Field 34	Diagnostic Confirmation	490
Not collected by OCISS	RX Hosp – Surg Prim Site	670
Not collected by OCISS	RX Hosp – Scope Reg LN Sur	672
Not collected by OCISS	RX Hosp – Surg Oth Reg/Dis	674
Field 49	Surgery Code	1290
Field 72	RX Summ – Scope Reg LN Sur	1292
Field 73	RX Summ – Surg Oth Reg/Dis	1294
Field 100	SEER Summary Stage 2000	759
Field 100	SEER Summary Stage 1977	760
Field 104	Regional Nodes Positive	820
Field 103	Regional Nodes Examined	830
Field 50	RX Date -- Surgery	1200
Field 74	Reason for No Surgery	1340
Field 67	RX Summ – Surg/Rad Seq	1380
Field 69	RX Summ – Systemic/Sur Seq	1639

Field 48) DATE OF FIRST COURSE OF THERAPY

Item Length: 8

NAACCR Item #1270

Source of Information: *FORDS: Revised for 2010*

Description

Records the date on which treatment (surgery, radiation, systemic, or other therapy) of the patient began at any facility.

Rationale

It is important to be able to measure the delay between diagnosis and the onset of treatment. A secondary use for this date is as a starting point for survival statistics (rather than using the diagnosis date). This date cannot be calculated from the respective first course treatment modality dates if no treatment was given. Therefore, providing the date on which active surveillance is chosen, a physician decides not to treat a patient, or a patient’s family or guardian declines treatment is important.

Instructions for Coding

- Record the earliest of the following dates: *Date of First Surgical Procedure* (NAACCR Item #1200), *Date Radiation Started* (NAACCR Item #1210), *Date Systemic Therapy Started* (NAACCR Item #3230), or *Date Other Treatment Started* (NAACCR Item #1250).
- If active surveillance or watchful waiting is selected as the first course of treatment (*RX Summ-Treatment Status* [NAACCR Item #1285] = 2) record the date this decision is made.
- In cases of nontreatment (*RX Summ-Treatment Status* [NAACCR Item #1285] = 0), in which a physician decides not to treat a patient or a patient’s family or guardian declines all treatment, the date of first course of treatment is the date this decision was made.
- Leave this item blank if the cancer was diagnosed at autopsy and not suspected prior to that.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of First Course of Treatment* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of First Course of Treatment* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date 1st Crs RX Flag* (NAACCR Item #1271) is used to explain why *Date of First Course of Treatment* is not a known date. See *Date 1st Crs RX Flag* for an illustration of the relationships among these items.

Examples

Code	Reason
February 14, 2004	A patient has a core biopsy on February 12, 2004 and subsequently undergoes an excisional biopsy on February 14, 2004.
April 21, 2005	A patient begins receiving preoperative radiation therapy elsewhere on April 21, 2005 and subsequent surgical therapy at this facility on June 2, 2005.

Field 48a) TREATMENT STATUS

Item Length: 1
 Allowable Values: 0-2, 9
 NAACCR Item #1285
 Source of Information: *FORDS: Revised for 2010*

Description

This data item summarizes whether the patient received any treatment or the tumor was under active surveillance.

Rationale

This item documents active surveillance (watchful waiting) and eliminates searching each treatment modality to determine whether treatment was given. It is used in conjunction with *Date of First Course of Treatment* (NAACCR Item #1270) to document whether treatment was or was not given, it is unknown if treatment was given, or treatment was given on an unknown date.

Instructions for Coding

- This item may be left blank for cases 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

Examples

Code	Reason
0	An elderly patient with pancreatic cancer requested no treatment.
0	Patient is expected to receive radiation, but it has not yet occurred yet (<i>Reason for No Radiation</i> [NAACCR Item #1430]=8)
2	Treatment plan for a lymphoma patient is active surveillance.

Field 49) CODE (First Course of Therapy - Surgery)

Item Length: 2
 Allowable Values: 00, 10-80, 90, 98, 99
 NAACCR Item #1290
 Source of Information: *FORDS: Revised for 2010*

Description

Records the surgical procedure(s) performed to the primary site.

Rationale

This data item can be used to compare the efficacy of treatment options.

Instructions for Coding

- Site-specific codes for this data item are found in Appendix 9 of this manual or *FORDS: Revised for 2010* Appendix B.
- If registry software allows only one procedure to be collected, document the most invasive surgical procedure for the primary site.
- If registry software allows multiple procedures to be recorded, this item refers to the most invasive surgical procedure of the primary site.
- 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 not available.
- Excisional biopsies (those that remove the entire tumor and/or leave only microscopic margins) are to be coded in this item.
- 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 9 of this manual or *FORDS: Revised for 2010* Appendix B.
- 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.
- If the procedure coded in this item was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care* (NAACCR Item # 3270).
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.

Code	Label	Definition
00	None	No surgical procedure of primary site. Diagnosed at autopsy.
10-19	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to Appendix 9 of this manual or <i>FORDS: Revised for 2010</i> Appendix B for the correct site-specific code for this procedure.
20-80	Site-specific codes; resection	Refer to Appendix 9 of this manual or <i>FORDS: Revised for 2010</i> Appendix B for the correct site-specific code for the procedure.
90	Surgery, NOS	A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.
98	Site-specific codes; special	Special code. Refer to Appendix 9 of this manual or <i>FORDS: Revised for 2010</i> Appendix B for the correct site-specific code for the procedure.
99	Unknown	Patient record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.

Field 50) DATE (First Course of Therapy-Surgery)

Item Length: 8

NAACCR Item #1200

Source of Information: *FORDS: Revised for 2010*

Description

Records the earliest date on which any first course surgical procedure was performed. Formerly called “Date of Cancer-Directed Surgery.”

Rationale

This item can be used to sequence multiple treatment modalities and to evaluate the time intervals between treatments.

Instructions for Coding

- Record the date of the first surgical procedure of the types coded as *Surgical Procedure of Primary Site* (NAACCR Item #1290), *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) or *Surgical Procedure/Other Site* (NAACCR Item #1294) performed at this or any facility.
- The date in this item may be the same as that in *Date of Most Definitive Surgical Resection of the Primary Site* (NAACCR Item #3170), if the patient received only one surgical procedure and it was a resection of the primary site.
- If surgery is the first or only treatment administered to the patient, then the date of surgery should be the same as the date entered into the item *Date of First Course Treatment* (NAACCR Item #1270).
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of First Surgical Procedure* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of First Surgical Procedure* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date-Surgery Flag* (NAACCR Item #1201) is used to explain why *Date of First Surgical Procedure* is not a known date. See *RX Date-Surgery Flag* for an illustration of the relationships among these items.

Examples

Code	Reason
March 23, 2008	A melanoma patient had an excisional biopsy on March 23, 2008, then a wide excision on March 28, 2008.
November 16, 2009	The patient had a small (0.5 cm) lump removed from her breast on November 16, 2009.
March 27, 2007	The patient’s primary tumor was treated with radiation beginning on April 16, 2007, after a distant metastasis was removed surgically on March 27, 2007.

Field 50a) DATE (First Course of Therapy-Surgery) FLAG

Item Length: 2
 Allowable Values: 10-12, Blank
 NAACCR Item # 1201
 Source of Information: *FORDS: Revised for 2010*

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of First Surgical Procedure* (NAACCR Item #1200).

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Instructions for Coding

- Leave this item blank if *Date of First Surgical Procedure* (NAACCR Item #1200) has a full or partial date recorded.
- Code 12 if the *Date of First Surgical Procedure* cannot be determined, but the patient did receive first course surgery.
- Code 10 if it is unknown whether any surgery was performed.
- Code 11 if no surgical procedure was performed.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed).
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item <i>Date of First Surgical Procedure</i> (NAACCR Item #1200).

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of First Surgical Procedure* (NAACCR Item #1200) and *Rx Date – Surgery Flag* (NAACCR Item #1201). ***In this table, the lower-case letter “b” is used to represent each blank space.***

Description	Traditional Date of First Surgical Procedure	Interoperable Date of First Surgical Procedure	Rx Date – Surgery Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any surgery performed	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No surgery performed	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, surgery performed	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

Field 51) TEXT (First Course of Therapy - Surgery)

Item Length: 1000

Allowable Values: Letters and Numbers

NAACCR Item #2610

Source of Information: *NAACCR Data Dictionary, Version 12*

Description

Text area for information describing all surgical procedures performed as part of treatment.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should be generated electronically from coded values.

Instructions for Coding

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized. (See Appendix 8.)
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date of each procedure
- Type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites
- Lymph nodes removed
- Regional tissues removed
- Metastatic sites
- Facility where each procedure was performed
- Record both positive and negative findings. Record positive test results first.
- Other treatment information, e.g., planned procedure aborted; unknown if surgery performed.

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

OCISS Field Number	OCISS Field Name	NAACCR Item Number
Not collected by OCISS	Date of Initial RX--SEER	1260
Field 48	Date of First Course of Therapy	1270
Field 50	RX Date--Surgery	1200
Field 49	Surgery Code	1290
Not collected by OCISS	RX Hosp – Surg Prim Site	670
Field 72	Scope of Regional Lymph Node Surgery	1292
Not collected by OCISS	RX Hosp – Scope Reg LN Sur	672
Field 73	Surgery of Other Regional Site(s), or Distant Lymph Nodes	1294
Not collected by OCISS	RX Hosp – Surg Oth Reg/Dis	674
Field 74	If NO Cancer Directed Surgery, Reason for NO Surgery	1340
Field 71	Surgical Margins (Surgical Margins of the Primary Site)	1320
Not collected by OCISS	RX Hosp – Palliative Proc	3280
Not collected by OCISS	RX Summ – Palliative Proc	3270
Not collected by OCISS	Text-Place of Diagnosis	2690
Field 67	RX Summ—Surg/Rad Seq	1380
Field 69	RX Summ—Systemic/Sur Seq	1639

Field 52) CODE (First Course of Therapy - Radiation)

Item Length: 1

Allowable Values: 0-9

NAACCR Item #1360

Source of Information: *NAACCR Data Dictionary, Version 12*

Description

Codes for the type of radiation therapy performed as part of the first course of treatment.

Note: Radiation to brain and central nervous system for leukemia and lung cases is coded as radiation in this field.

Instructions for Coding

Code	Definition
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	Currently allowable for historic cases only; see note below
7	Patient or patient's guardian refused*
8	Radiation recommended, unknown if administered*
9	Unknown if radiation administered

* *Note:* CoC discontinued collection of this item in 2003 when *FORDS* was implemented. For CoC, codes 7 and 8 were used for tumors diagnosed before 1996, but should have been converted to 0 in this field and to the appropriate code in the new field Reason for No Radiation [1430]. SEER continues to use codes 7 and 8 for all years. See Chapter V, Unresolved Issues, for further discussion.

In the SEER program, a code 2 for other radiation was used between 1973 and 1987. When the radiation codes were expanded to add codes '2' radioactive implants and '3' radioisotopes, all cases with a code '2' and diagnosed in 1973-1987 were converted to a code '6' radiation other than beam radiation.

Field 53) DATE (First Course of Therapy - Radiation)

Item Length: 8

NAACCR Item #1210

Source of Information: *FORDS: Revised for 2010*

Description

Records the date on which radiation therapy began at any facility that is part of the first course of treatment.

Rationale

It is important to be able to sequence the use of multiple treatment modalities and to evaluate the time intervals between the treatments. For some diseases, the sequence of radiation and surgical therapy is important when determining the analytic utility of pathologic stage information.

Instructions for Coding

- If radiation therapy is the first or only treatment administered to the patient, then the date radiation started should be the same as the date entered into the item *Date of First Course of Treatment* (NAACCR Item #1270).
- The date when treatment started will typically be found in the radiation oncologist’s summary letter for the first course of treatment.
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Radiation Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Radiation Started* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date-Radiation Flag* (NAACCR Item #1211) is used to explain why *Date Radiation Started* is not a known date. See *RX Date-Radiation Flag* for an illustration of the relationships among these items.

Examples

Code	Reason
December 15, 2003	A patient has external beam radiation on December 15, 2003.
October 12, 2003	A patient with a primary tumor of the brain undergoes stereotactic radiosurgery using a Gamma Knife on October 12, 2003.
June 2, 2003	A patient enters the facility for interstitial radiation boost for prostate cancer that is performed on August 6, 2003. Just prior to this, the patient had external beam therapy to the lower pelvis that was started on June 2, 2003 at another facility.

Field 53a) DATE (First Course of Therapy - Radiation) FLAG

Item Length: 2
 Allowable Values: 10-12, 15, Blank
 NAACCR Item # 1211
 Source of Information: *FORDS: Revised for 2010*

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date Radiation Started* (NAACCR Item # 1210).

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Instructions for Coding

- Leave this item blank if *Date Radiation Started* (NAACCR Item #1210) has a full or partial date recorded.
- Code 12 if the *Date Radiation Started* cannot be determined, but the patient did receive first course radiation.
- Code 10 if it is unknown whether any radiation was given.
- Code 11 if no radiation is planned or given.
- Code 15 if radiation is planned, but has not yet started and the start date is not yet available. Follow this patient for radiation treatment and update this item, *Date Radiation Started*, and all other radiation items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any radiation given).
11	No proper value is applicable in this context (for example, no radiation given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (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 (for example, radiation therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
(blank)	A valid date value is provided in item <i>Date Radiation Started</i> (NAACCR Item #1210).

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Radiation Started* (NAACCR Item #1210) and *Rx Date – Radiation Flag* (NAACCR Item #1211). ***In this table, the lower-case letter “b” is used to represent each blank space.***

Description	Traditional Date Radiation Started	Interoperable Date Radiation Started	Rx Date – Radiation Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999)	Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any radiation given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No radiation given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, radiation given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12
Radiation is planned, not yet begun	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

Field 54) TEXT (First Course of Therapy – Radiation)

Item Length: 1000

Allowable Values: Letters and Numbers

NAACCR Item #2620

Source of Information: *NAACCR Data Dictionary, Version 12*

Description

Text area for manual documentation of information regarding treatment of the tumor being reported with beam and other radiation.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Instructions for Coding

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See Appendix 8 of this manual).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date when radiation treatment began
- Where treatment was given, e.g., at this facility, at another facility
- Type(s) of beam radiation, e.g., Orthovoltage, Cobalt 60, MV X-rays, Electrons, Mixed modalities
- Other treatment information, e.g., patient discontinued after 5 treatments; unknown if radiation was given

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

OCISS Field Number	OCISS Field Name	NAACCR Item Number
Not collected by OCISS	Date of Initial RX--SEER	1260
Field 48	Date of First Course of Therapy	1270
Field 52	Code (First Course of Therapy - Radiation)	1360
Field 67	Radiation Surgery Sequence	1380
Field 68a	If NO Radiation, Reason for No Radiation	1430
Field 53	Date (First Course of Therapy - Radiation)	1210
Field 68	Radiation Regional Rx Modality	1570
Not collected by OCISS	RX Hosp – Radiation	690
Not collected by OCISS	RX Date Radiation Ended	3220
Not collected by OCISS	RX Summ – Rad to CNS	1370
Not collected by OCISS	Rad-No of Treatment Vol	1520
Not collected by OCISS	Rad-Regional Dose cGy	1510
Not collected by OCISS	Rad Treatment Volume	1540
Not collected by OCISS	Rad Location of RX	1550
Not collected by OCISS	Rad Boost RX Modality	3220
Not collected by OCISS	Rad Boost Dose cGy	3210

Field 55) CODE (First Course of Therapy - Chemotherapy)

Item Length: 2

Allowable Values: 00-03, 82, 85-88, 99

NAACCR Item #1390

Source of Information: *FORDS: Revised for 2010*

Description

Records the type of chemotherapy administered as first course treatment at this and all other facilities. If chemotherapy was not administered, then this item records the reason it was not administered to the patient. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of chemotherapeutic agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if chemotherapy was not administered.

Instructions for Coding

- Code 00 if chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include chemotherapy.
- If it is known that chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended the patient receive chemotherapy but no further documentation is available yet to confirm its administration.
- Code 88 to indicate referral was made to a medical oncologist and the registry must follow to determine whether it was given. If follow-up with the specified specialist or facility indicates the patient was never there, code 00.
- Cases coded 88 must be followed to determine what kind of chemotherapy was administered or why it was not.
- Code 99 if it is not known whether chemotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered.
- Code chemoembolization as 01, 02, or 03 depending on the number of chemotherapeutic agents involved.
- If the managing physician changes one of the agents in a combination regimen, and the replacement agent belongs to a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen represents the start of subsequent therapy, and *only the original agent or regimen is recorded as first course therapy*.
- Refer to the *SEER*Rx Interactive Drug Database* (<http://seer.cancer.gov/>) for a list of chemotherapeutic agents.
- If chemotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the chemotherapy administered in the item *Palliative Care* NAACCR Item #3270).

Code	Definition
00	None, chemotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Chemotherapy administered as first course therapy, but the type and number of agents is not documented in the patient record.
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 (i.e., comorbid conditions, advanced age, progression of tumor prior to administration, etc.).
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 patient record.
87	Chemotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member or the patient's guardian. The refusal was noted in patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples

Code	Reason
01	A patient with primary liver cancer is known to have received chemotherapy, however, the name(s) of agent(s) administered is not stated in patient record.
02	A patient with Stage III colon cancer is treated with a combination of fluorouracil and levamisole. Code the administration of fluorouracil as single agent chemotherapy, and levamisole as an immunotherapeutic agent.
02	A patient with non-Hodgkin's lymphoma is treated with fludarabine.
03	A patient with early stage breast cancer receives chemotherapy. The patient chart indicates that a regimen containing doxorubicin is to be administered.
86	Following surgical resection of an ovarian mass the following physician recommends chemotherapy. The patient record states that chemotherapy was not subsequently administered to the patient, but the reason why chemotherapy was not administered is not given.

Field 56) DATE (First Course of Therapy - Chemotherapy)

Item Length: 8

NAACCR Item #1220

Source of Information: *FORDS: Revised for 2010*

Description

Records the date of initiation of chemotherapy that is part of the first course of treatment.

Rationale

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Instructions for Coding

- Record the first or earliest date on which chemotherapy was administered by any facility. This date corresponds to administration of the agents coded in *Chemotherapy* (NAACCR Item #1390).
- This item was required in the past but discontinued in FORDS as a required item in 2003. If the date was not collected between 2003 and 2009, this field may be left blank. However, if it was collected for cases diagnosed in those years, it should be retained in this field.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Chemotherapy Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Chemotherapy Started* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date-Chemo Flag* (NAACCR Item #1221) is used to explain why *Date Chemotherapy Started* is not a known date. See *RX Date-Chemo Flag* for an illustration of the relationships among these items.

Field 56a) DATE (First Course of Therapy - Chemotherapy) FLAG

Item Length: 2
 Allowable Values: 10-12, 15, Blank
 NAACCR Item # 1221
 Source of Information: *FORDS: Revised for 2010*

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date Chemotherapy Started* (NAACCR Item # 1220).

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Instructions for Coding

- Leave this item blank if *Date Chemotherapy Started* (NAACCR Item #1220) has a full or partial date recorded.
- Code 12 if the *Date Chemotherapy Started* cannot be determined, but the patient did receive first course chemotherapy.
- Code 10 if it is unknown whether any chemotherapy was given.
- Code 11 if no chemotherapy is planned or given.
- Code 15 if chemotherapy is planned, but not yet started. Follow this patient for chemotherapy and update this item, *Date Chemotherapy Started*, and the relevant chemotherapy items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave this item blank for diagnoses between 2003 and 2009 (inclusive) if this facility did not collect *Date Chemotherapy Started* at that time.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any chemotherapy was given).
11	No proper value is applicable in this context (for example, no chemotherapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, chemotherapy 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, chemotherapy is planned as part of the first course of therapy, but had not yet started at the time of the last follow-up).
(blank)	A valid date value is provided in item <i>Date Chemotherapy Started</i> (NAACCR Item #1220). Case was diagnosed between 2003 and 2009 and the facility did not record <i>Date Chemotherapy Started</i> (NAACCR Item #1220) at that time.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Chemotherapy Started* (NAACCR Item #1220) and *Rx Date – Chemo Flag* (NAACCR Item #1221). ***In this table, the lower-case letter “b” is used to represent each blank space.***

Description	Traditional Date Chemotherapy Started	Interoperable Date Chemotherapy Started	Rx Date – Chemo Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999)	Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any chemotherapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No chemotherapy given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, chemotherapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12
Chemotherapy is planned, not yet begun	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

Field 57) TEXT (First Course of Therapy - Chemotherapy)

Item Length: 1000

Allowable Values: Letters and Numbers

NAACCR Item #2640

Source of Information: *NAACCR Data Dictionary, Version 12*

Description

Text area for manual documentation of information regarding chemotherapy treatment of the reported tumor.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Instructions for Coding

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized. (See Appendix 8.)
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date when chemotherapy began
- Where treatment was given, e.g., at this facility, at another facility
- Type(s) of chemotherapy, e.g., name of agent(s) or protocol
- Other treatment information, e.g., treatment cycle incomplete, unknown if chemotherapy was given

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

OCISS Field Number	OCISS Field Name	NAACCR Item Number
Not collected by OCISS	Date of Initial RX -- SEER	1260
Field 48	Date of First Course of Therapy	1270
Field 55	Code (First Course of Therapy - Chemotherapy)	1390
Not collected by OCISS	RX Hosp -- Chemo	700
Not collected by OCISS	RX Date -- Systemic	3230
Field 56	Date (First Course of Therapy - Chemotherapy)	1220
Field 69	RX Summ -- Systemic/Sur Seq	1639

Field 58) CODE (First Course of Therapy - Hormone - Hormone/Steroid Therapy)

Item Length: 2

Allowable Values: 00-01, 82, 85-88, 99

NAACCR Item #1400

Source of Information: *FORDS: Revised for 2010***Description**

Records the type of hormone administered as first course treatment at this and all other facilities. If hormone therapy was not administered, then this item records the reason it was not administered to the patient. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of hormonal agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if hormone therapy was not administered.

Instructions for Coding

- 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.
- 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.
- Code 00 if hormone therapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include hormone therapy.
- Code 01 for thyroid replacement therapy which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.
- If it is known that hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended hormone therapy, but no further documentation is available yet to confirm its administration.
- Code 88 to indicate the patient was referred to a medical oncologist and the registry should follow the case for hormone therapy. If follow-up with the specified specialist or facility indicates the patient was never there, code 00.
- Cases coded 88 must be followed to determine whether they received hormone therapy or why not.
- Code 99 if it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- Refer to the *SEER*Rx Interactive Drug Database* (<http://seer.cancer.gov/>) for a list of hormonal agents.
- If hormone therapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hormone therapy administered in the item *Palliative Care* (NAACCR Item #3270).

Code	Definition
00	None, hormone therapy was not part of the first planned course of therapy. Diagnosed at autopsy.
01	Hormone therapy administered as first course therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration, etc.).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples

Code	Reason
00	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 symptoms. Decadron is not coded as hormonal therapy.
00	A patient with breast cancer may be treated with aminoglutethimide (Cytadren, Elipten), which suppresses the production of glucocorticoids and mineralocorticoids. This patient must take glucocorticoid (hydrocortisone) and may also need a mineralocorticoid (Florinef) as a replacement therapy.
00	A patient with advanced disease is given prednisone to stimulate the appetite and improve nutritional status. Prednisone is not coded as hormone therapy.
01	A patient with metastatic prostate cancer is administered flutamide (an antiestrogen).
87	A patient with metastatic prostate cancer declines the administration of Megace (a progestational agent) and the refusal is noted in the patient record.

Field 59) DATE (First Course of Therapy - Hormone - Hormone/Steroid Therapy)

Item Length: 8

NAACCR Item #1230

Source of Information: *FORDS: Revised for 2010*

Description

Records the date of initiation of hormone therapy that is part of the first course of treatment.

Rationale

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Instructions for Coding

- Record the first or earliest date on which hormone therapy was administered by any facility. This date corresponds to administration of the agents coded in Hormone Therapy (NAACCR Item #1390).
- This item was required in the past but discontinued in FORDS as a required item in 2003. If the date was not collected between 2003 and 2009, this field may be left blank. However, if it was collected for cases diagnosed in those years, it should be retained in this field.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Hormone Therapy Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Hormone Therapy Started* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date-Hormone Flag* (NAACCR Item #1231) is used to explain why *Date Hormone Therapy Started* is not a known date. See *RX Date-Hormone Flag* for an illustration of the relationships among these items.

Field 59a) DATE (First Course of Therapy - Hormone - Hormone/Steroid Therapy) FLAG

Item Length: 2

Allowable Values: 10-12, 15, Blank

NAACCR Item # 1231

Source of Information: *FORDS: Revised for 2010*

Description

This flag explains why there is no appropriate value in the field, *Date Hormone Therapy Started* (NAACCR Item #1230).

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Instructions for Coding

- Leave this item blank if *Date Hormone Therapy Started* (NAACCR Item #1230) has a full or partial date recorded.
- Code 12 if the *Date Hormone Therapy Started* cannot be determined, but the patient did receive first course hormone therapy.
- Code 10 if it is unknown whether any hormone therapy was given.
- Code 11 if no hormone therapy is planned or given.
- Code 15 if hormone therapy is planned, but not yet started. Follow this patient for hormone therapy and update this item, *Date Hormone Therapy Started*, and the relevant hormone therapy items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave this item blank for diagnoses between 2003 and 2009 if this facility did not collect *Date Hormone Therapy Started* at that time.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any hormone therapy was given).
11	No proper value is applicable in this context (for example, no hormone therapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, hormone therapy 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, hormone therapy is planned as part of the first course of therapy, but had not yet started at the time of the last follow-up).
(blank)	A valid date value is provided in item <i>Date Hormone Therapy Started</i> (NAACCR Item #1230). Case was diagnosed between 2003 and 2009 and the facility did not record <i>Date Hormone Therapy Started</i> (NAACCR Item #1230) at that time.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Hormone Therapy Started* (NAACCR Item #1230) and *Rx Date – Hormone Flag* (NAACCR Item #1231). ***In this table, the lower-case letter “b” is used to represent each blank space.***

Description	Traditional Date Hormone Therapy Started	Interoperable Date Hormone Therapy Started	Rx Date – Hormone Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999)	Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any hormone therapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No hormone therapy given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, hormone therapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12
Hormone therapy is planned, not yet begun	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

Field 60) TEXT (First Course of Therapy - Hormone - Hormone/Steroid Therapy)

Item Length: 1000

Allowable Values: Letters and Numbers

NAACCR Item #2650

Source of Information: *NAACCR Data Dictionary, Version 12*

Description

Text area for information about hormonal treatment.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should be generated electronically from coded values.

Instructions for Coding

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized. (See Appendix 8.)
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date treatment was started
- Where treatment was given, e.g., at this facility, at another facility
- Type of hormone or antihormone, e.g., Tamoxifen
- Type of endocrine surgery or radiation, e.g., orchiectomy
- Other treatment information, e.g., treatment cycle incomplete; unknown if hormones were given

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

OCISS Field Number	OCISS Field Name	NAACCR Item Number
Not collected by OCISS	Date of Initial RX--SEER	1260
Field 48	Date of First Course of Therapy	1270
Field 58	Hormone/Steroid Therapy-Code	1400
Not collected by OCISS	RX Hosp -- Hormone	710
Not collected by OCISS	RX Date -- Systemic	3230
Field 59	Hormone/Steroid Therapy-Date	1230
Not collected by OCISS	RX Summ – System/Sur Seq	1639

Field 61) CODE (First Course of Therapy - BRM - Immunotherapy)

Item Length: 2

Allowable Values: 00-01, 82, 85-88, 99

NAACCR Item #1410

Source of Information: *FORDS: Revised for 2010*

Description

Records the type of immunotherapy administered as first course treatment at this and all other facilities. If immunotherapy was not administered, then this item records the reason it was not administered to the patient. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of immunotherapeutic agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if immunotherapy was not administered.

Instructions for Coding

- Code 00 if immunotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include immunotherapy.
- If it is known that immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended immunotherapy, but no further documentation is available yet to confirm its administration.
- Code 88 to indicate a referral was made to a medical oncologist about immunotherapy and the registry should follow the case to determine whether it was given or why not. If follow-up with the specified specialist or facility indicates the patient was never there, code 00.
- Cases coded 88 should be followed and the code updated as appropriate.
- Code 99 if it is not known whether immunotherapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- Refer to the *SEER*Rx Interactive Drug Database* (<http://seer.cancer.gov/>) for a list of immunotherapeutic agents.
- If immunotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the immunotherapy administered in the item *Palliative Care* (NAACCR Item #3270).

Code	Definition
00	None, immunotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Immunotherapy administered as first course therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration, etc.).
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples

Code	Reason
01	A patient with malignant melanoma is treated with interferon.
85	Before recommended immunotherapy could be administered, the patient died from cancer.

Field 62) DATE (First Course of Therapy - BRM - Immunotherapy)

Item Length: 8

NAACCR Item #1240

Source of Information: *FORDS: Revised for 2010*

Description

Records the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of treatment.

Rationale

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Instructions for Coding

- Record the first or earliest date on which immunotherapy or a biologic response modifier was administered by any facility. This date corresponds to administration of the agents coded in *Immunotherapy* (NAACCR Item #1410).
- This item was required in the past but discontinued in FORDS as a required item in 2003. If the date was not collected between 2003 and 2009, this field may be left blank. However, if it was collected for cases diagnosed in those years, it should be retained in this field.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Immunotherapy Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Immunotherapy Started* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date-BRM Flag* (NAACCR Item #1241) is used to explain why *Date Immunotherapy Started* is not a known date. See *RX Date-BRM Flag* for an illustration of the relationships among these items.

Field 62a) DATE (First Course of Therapy - BRM - Immunotherapy) FLAG

Item Length: 2

Allowable Values: 10-12, 15, Blank

NAACCR Item # 1241

Source of Information: *FORDS: Revised for 2010*

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date Immunotherapy Started* (NAACCR Item #1240).

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Instructions for Coding

- Leave this item blank if *Date Immunotherapy Started* (NAACCR Item #1240) has a full or partial date recorded.
- Code 12 if the *Date Immunotherapy Started* cannot be determined, but the patient did receive first course immunotherapy or a biologic response modifier.
- Code 10 if it is unknown whether any immunotherapy or a biologic response modifier was given.
- Code 11 if no immunotherapy or biologic response modifier is planned or given.
- Code 15 if immunotherapy or a biologic response modifier is planned, but not yet started. Follow this patient for immunotherapy and update this item, *Date Immunotherapy Started*, and the relevant immunotherapy items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave this item blank for diagnoses between 2003 and 2009 if this facility did not collect *Date Immunotherapy Started* at that time.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any immunotherapy was given).
11	No proper value is applicable in this context (for example, no immunotherapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, immunotherapy was given but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, immunotherapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
Blank	A valid date value is provided in item <i>Date Immunotherapy Started</i> (NAACCR Item #1240). Case was diagnosed between 2003 and 2009 and the facility did not record <i>Date Immunotherapy Started</i> (NAACCR Item #1240) at that time.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Immunotherapy Started* (NAACCR Item #1240) and *Rx Date – BRM Flag* (NAACCR Item #1241). *In this table, the lower-case letter “b” is used to represent each blank space.*

Description	Traditional Date Immunotherapy Started	Interoperable Date Immunotherapy Started	Rx Date – BRM Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999)	Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any immunotherapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No immunotherapy given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, immunotherapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12
Immunotherapy is planned, not yet begun	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

Field 63) TEXT (First Course of Therapy - BRM - Immunotherapy)

Item Length: 1000

Allowable Values: Letters and Numbers

NAACCR Item #2660

Source of Information: *NAACCR Data Dictionary, Version 12*

Description

Text area for manual documentation of information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Instructions for Coding

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized. (See Appendix 8.)
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date treatment began
- When treatment was given, e.g., at this facility; at another facility
- Type of BRM agent, e.g., Interferon, BCG
- BRM procedures, e.g., bone marrow transplant, stem cell transplant
- Other treatment information, e.g., treatment cycle incomplete, unknown if BRM was given

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

OCISS Field Number	OCISS Field Name	NAACCR Item Number
Not collected by OCISS	Date of Initial RX -- SEER	1260
Field 48	Date of First Course of therapy	1270
Not collected by OCISS	RX Hosp -- BRM	720
Not collected by OCISS	RX Date Systemic	3230
Field 70	RX Summ Transplnt/Endocr	3250
Field 61	Code-BRM-Immunotherapy	1410
Field 62	Date-BRM-Immunotherapy	1240
Field 69	RX Summ -- Systemic/Sur Seq	1639

Field 64) CODE (First Course of Therapy - Other)

Item Length: 1

Allowable Values: 0-3, 6-9

NAACCR Item #1420

Source of Information: *FORDS: Revised for 2010*

Description

Identifies other treatment that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.

Rationale

Information on other therapy is used to describe and evaluate the quality of care and treatment practices.

Instructions for Coding

- The principal treatment for certain reportable hematopoietic diseases could be supportive care that does not meet the usual definition of treatment that “modifies, controls, removes, or destroys” proliferating cancer tissue. Supportive care may include phlebotomy, transfusion, or aspirin. In order to report the hematopoietic cases in which the patient received supportive care, SEER and the Commission on Cancer have agreed to record treatments such as phlebotomy, transfusion, or aspirin as “Other Treatment” (Code 1) for the hematopoietic diseases ONLY. (See instructions for coding in Section One).
- Code 1 for embolization using alcohol as an embolizing agent.
- Code 1 for embolization to a site other than the liver where the embolizing agent is unknown.
- Do not code presurgical embolization that is given for a purpose to shrink the tumor.
- A complete description of the treatment plan should be recorded in the text field for “Other Treatment” on the abstract.
- If other treatment was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the other treatment administered in the item *Palliative Care* (NAACCR Item #3270).
- Code 8 if it is known that a physician recommended treatment coded as Other Treatment, and no further documentation is available yet to confirm its administration.
- Code 8 to indicate referral to a specialist for Other Treatment and the registry should follow. If follow-up with the specialist or facility determines the patient was never there, code 0.

Code	Label	Definition
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment. Diagnosed at autopsy.
1	Other	Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic).
2	Other--Experimental	This code is not defined. It may be used to record participation in institution-based clinical trials.
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	Cancer treatments administered by nonmedical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient’s physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient’s family member, or the patient’s guardian. The refusal was noted in the patient record.
8	Recommended; unknown if administered	Other treatment was recommended, but it is unknown whether it was administered.
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment. Death certificate only.

Field 65) DATE (First Course of Therapy - Other)

Item Length: 8

NAACCR Item #1250

Source of Information: *FORDS: Revised for 2010*

Description

Records the date on which other treatment began at any facility.

Rationale

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Instructions for Coding

- Record the date on which the care coded as *Other Treatment* (NAACCR Item #1420) was initiated.
- If other treatment is the first or only treatment administered to the patient, then the date other treatment started should be the same as the *Date of First Course of Treatment* (NAACCR Item #1270).
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Other Treatment Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Other Treatment Started* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date-Other Flag* (NAACCR Item #1251) is used to explain why *Date Other Treatment Started* is not a known date. See *RX Date-Other Flag* for an illustration of the relationships among these items.

Examples

Code	Reason
March 16, 2010	A patient with metastatic disease was started on an experimental therapy on March 16, 2010.
August 1, 2009	Alcohol was used as an embolizing agent for a patient on August 1, 2009.
September 17, 2008	A polycythemia vera patient was given several phlebotomies, the first being on September 17, 2008.

Field 65a) DATE (First Course of Therapy - Other) FLAG

Item Length: 2

Allowable Values: 10-12, Blank

NAACCR Item # 1251

Source of Information: *FORDS: Revised for 2010*

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date Other Treatment Started* (NAACCR Item #1250).

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Instructions for Coding

- Leave this item blank if *Date Other Treatment Started* (NAACCR Item #1250) has a full or partial date recorded.
- Code 12 if the *Date Other Treatment Started* cannot be determined, but the patient did receive first course other treatment.
- Code 10 if it is unknown whether any other treatment was given (*Other Treatment* [NAACCR Item #1420] is 9).
- Code 11 if no other treatment is planned or given (*Other Treatment* [NAACCR Item #1420] is 0, 7 or 8).
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any Other Treatment was given).
11	No proper value is applicable in this context (for example, no Other Treatment given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, Other Treatment was given but the date is unknown).
Blank	A valid date value is provided in item <i>Date Other Treatment Started</i> (NAACCR Item #1250).

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Other Treatment Started* (NAACCR Item #1250) and *Rx Date – Other Flag* (NAACCR Item #1251). ***In this table, the lower-case letter “b” is used to represent each blank space.***

Description	Traditional Date Other Treatment Started	Interoperable Date Other Treatment Started	Rx Date – Other Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999)	Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if other treatment given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No other treatment given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, other treatment given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

Field 66) TEXT (First Course of Therapy - Other)

Item Length: 1000

Allowable Values: Letters and Numbers

NAACCR Item #2670

Source of Information: *NAACCR Data Dictionary, Version 12*

Description

Text area for manual documentation of information regarding the treatment of the tumor being reported with treatment that cannot be defined as surgery, radiation, or systemic therapy. This includes experimental treatments (when the mechanism of action for a drug is unknown), and blinded clinical trials. If the mechanism of action for the experimental drug is known, code to the appropriate treatment field.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should not be entered manually from the medical record and should be generated electronically from coded values.

Instructions for Coding

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized. (See Appendix 8.)
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date treatment was started
- Where treatment was given, e.g., at this facility; at another facility
- Type of other treatment, e.g., blinded clinical trial, hyperthermia
- BRM procedures, e.g., bone marrow transplant, stem cell transplant
- Other treatment information, e.g., treatment cycle incomplete, unknown if other treatment was given

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

OCISS Field Number	OCISS Field Name	NAACCR Item Number
Not collected by OCISS	Date of Initial RX -- SEER	1260
Field 48	Date of First Course of Therapy	1270
Field 64	Code-Other	1420
Field 65	Date-Other	1250
Not collected by OCISS	RX Hosp -- Other	730

Field 67) RADIATION SURGERY SEQUENCE (First Course of Therapy – Surgery)

Item Length: 1

Allowable Values: 0, 2-6, 9

NAACCR Item #1380

Source of information: *FORDS: Revised for 2010*

Description

Records the sequencing of radiation and surgical procedures given as part of the first course of treatment.

Rationale

The sequence of radiation 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. This data item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Instructions for Coding

- Surgical procedures include *Surgical Procedure of Primary Site* (NAACCR Item #1290); *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292); *Surgical Procedure/Other Site* (NAACCR Item #1294). If all of these procedures are coded 0, or it is not known whether the patient received both surgery and radiation, then this item should be coded 0.
- If the patient received both radiation therapy and any one or a combination of the following surgical procedures: *Surgical Procedure of Primary Site*, *Regional Lymph Node Surgery*, or *Surgical Procedure/Other Site*, then code this item 2-9, as appropriate.

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; scope of regional lymph node surgery, 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; scope of regional lymph node surgery, 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; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
5	Intraoperative radiation therapy	Intraoperative therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s); distant site(s), or distant lymph node(s).
6	Intraoperative radiation therapy with other therapy administered before or after surgery	Intraoperative radiation therapy given during surgery to primary site; scope of regional lymph node surgery, 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; scope of regional lymph node surgery, 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; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record.

Examples

Code	Reason
0	Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain.
2	A large lung lesion received radiation therapy prior to resection.
3	A patient received a wedge resection of a right breast mass with axillary lymph node dissection followed by radiation to right breast.
4	Preoperative radiation therapy was given to a large, bulky vulvar lesion and was followed by a lymph node dissection. This was then followed by radiation therapy to treat positive lymph nodes.
5	A cone biopsy of the cervix was followed by intracavitary implant for IIIB cervical carcinoma.
6	Stage IV vaginal carcinoma was treated with 5,000 cGy to the pelvis followed by a lymph node dissection and 2,500 cGy of intracavitary brachytherapy.
9	An unknown primary of the head and neck was treated with surgery and radiation prior to admission, but the sequence is unknown. The patient enters for chemotherapy.

Field 68) RADIATION REGIONAL RX MODALITY (First Course of Therapy - Surgery)

Item Length: 2

Allowable Values: 00, 20-32, 40-43, 50-55, 60-62, 80, 85, 98, 99

NAACCR Item #1570

Source of Information: *FORDS: Revised for 2010*

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.

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 IMRT or conformal 3D whenever either is explicitly mentioned.
- Code radioembolization as brachytherapy.

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
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 in the range 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	Sterotactic 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, radioembolization, or intracavitary applicators of radioactive materials not otherwise specified.
51	Brachytherapy, Intracavitary, LDR	Intracavitary (no direct insertion into tissues) radio-isotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, Intracavitary, 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, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	
80*	Combined modality, specified*	Combination of external beam radiation and either radioactive implants or radioisotopes*
85*	Combined modality, NOS*	Combination of radiation treatment modalities not specified in code 80*
98	Other, NOS	Other radiation, NOS; Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

Examples

Code	Reason
20	A patient with prostate carcinoma receives pelvic irradiation at the reporting facility, and is then referred to a major medical center for experimental proton therapy boost.
24	A patient treated with breast conserving surgery has an interstitial boost at the time of the excisional biopsy. The implant uses Ir-192 and is left in place for three days. This is followed by 6 MV photon treatment of the entire breast. In this case, the “boost” precedes the regional treatment.
25	In an experimental program, a patient with a Stage III carcinoma of the prostate receives 4,500 cGy to the pelvis using 15 MV photons, and then the prostate receives a 600 cGy boost with neutrons.
25	Patient receives 15 MV external pelvic treatment to 4,500 cGy for cervical carcinoma, and then receives two Fletcher intracavitary implants.
29	A patient with carcinoma of the parotid receives daily treatments of which 60% are delivered by 15 MV photons and 40% of the dose is delivered by 16 MV electrons.
98	A patient with a head and neck cancer underwent regional radiation treatment elsewhere and was referred to reported facility for an HDR brachytherapy boost. Detailed treatment records from the other facility are not available.

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

Field 68a) REASON FOR NO RADIATION

Item Length: 1
 Allowable Values: 0-2, 5-9
 NAACCR Item # 1430
 Source of Information: *FORDS: Revised for 2010*

Description

Records the reason that no regional radiation therapy was administered to the patient.

Rationale

When evaluating the quality of care, it is useful to know the reason that various methods of therapy were not used, and whether the failure to provide a given type of therapy was due to the physician’s failure to recommend that treatment, or due to the refusal of the patient, a family member, or the patient’s guardian.

Instructions for Coding

- If *Regional Treatment Modality* (NAACCR Item #1570) is coded 00, then record the reason based on documentation in the patient record.
- Code 1 if the treatment plan offered multiple options and the patient selected treatment that did not include radiation therapy.
- Code 7 if the patient refused recommended radiation therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 8 if it is known that a physician recommended radiation treatment, but no further documentation is available yet to confirm its administration.
- Code 8 to indicate referral to a radiation oncologist was made and the registry should follow to determine whether radiation was administered. If follow-up to the specialist or facility determines the patient was never there and no other documentation can be found, code 1.
- Cases coded 8 should be followed and updated to a more definitive code as appropriate.
- Code 9 if the treatment plan offered multiple options, but it is unknown which treatment, if any, was provided.

Code	Definition
0	Radiation therapy was administered.
1	Radiation therapy was 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 (comorbid conditions, advanced age, progression of tumor prior to planned radiation, 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 the 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 the 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.

Example

Code	Reason
1	A patient with Stage I prostate cancer is offered either surgery or brachytherapy to treat his disease. The patient elects to be surgically treated.

Field 69) RX SUMM SYSTEMIC/SUR SEQ (First Course of Therapy - Surgery)

Item Length: 1

Allowable Values: 0, 2-6, 9

NAACCR Item #1639

Source of information: *FORDS: Revised for 2010*

Description

Records the sequencing of systemic therapy and surgical procedures given as part of the first course of treatment.

Rationale

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. This data item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Instructions for Coding

- *Systemic/Surgery Sequence* is to be used for patients diagnosed on or after January 1, 2006.
- Code the administration of systemic therapy in sequence with the first surgery performed, described in the item *Date of First Surgical Procedure* (NAACCR Item #1200).
- If none of the following surgical procedures was performed: *Surgical Procedure of Primary Site* (NAACCR Item #1290), *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292), *Surgical Procedure/Other Site* (NAACCR Item #1294), then this item should be coded 0.
- If the patient received both systemic therapy and any one or a combination of the following surgical procedures: *Surgical Procedure of Primary Site* (NAACCR Item #1290), *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292), or *Surgical Procedure/Other Site* (NAACCR Item #1294), then code this item 2-9, as appropriate.

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. It is unknown whether both surgery and systemic treatment were provided.
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 systemic 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.
9	Sequence unknown	Both surgery and systemic therapy were provided, but the sequence is unknown.

Examples

Code	Reason
0	Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain.
2	Patient with prostate cancer received hormone therapy prior to a radical prostatectomy.
3	Patient underwent a colon resection followed by a 5-FU based chemotherapy regimen.
4	Patient with breast cancer receives pre-operative chemotherapy followed by post-operative Tamoxifen.
5	Patient with intracranial primary undergoes surgery at which time a glial wafer is implanted into the resected cavity.
6	Patient with metastatic colon cancer receives intraoperative chemotherapy to the liver.
9	An unknown primary of the head and neck was treated with surgery and chemotherapy prior to admission, but the sequence is unknown. The patient enters for radiation therapy.

Field 70) RX SUMM TRANSPLNT/ENDOCR (Hematologic Transplant and Endocrine Procedures)**(First Course of Therapy - Surgery)**

Item Length: 2

Allowable Values: 00, 10-12, 20, 30, 40, 82, 85-88, 99

NAACCR Item #3250

Source of Information: *FORDS: Revised for 2010***Description**

Identifies systemic therapeutic *procedures* administered as part of the first course of treatment at this and all other facilities. If none of these *procedures* were administered, then this item records the reason they were not performed. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.

Rationale

This data item allows the evaluation of patterns of treatment which involve the alteration of the immune system or change the patient's response to tumor cells but does not involve the administration of antineoplastic agents. In addition, when evaluating the quality of care, it is useful to know the reason if these *procedures* were not performed.

Instructions for Coding

- Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogenic (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 allogenic.
- 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 affect 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 00 if a transplant or endocrine procedure was not administered to the patient, and it is known that these procedures are not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include a transplant or endocrine procedure.
- If it is known that a transplant or endocrine procedure is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused a recommended transplant or endocrine procedure, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended a hematologic transplant or endocrine procedure, but no further documentation is available yet to confirm its administration.
- Code 88 to indicate referral to a specialist for hematologic transplant or endocrine procedures and the registry should follow the case. If follow-up with the specified specialist or facility indicates the patient was never there, code 00.
- Cases coded 88 should be followed to determine whether they were given a hematologic transplant or endocrine procedure or why not.
- Code 99 if it is not known whether a transplant or endocrine procedure is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- If the hematologic transplant or endocrine procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hematologic transplant or endocrine procedure provided in the items *Palliative Care* (NAACCR Item #3270) and/or *Palliative Care at This Facility* (NAACCR Item #3280), as appropriate.

Code	Definition
00	No transplant procedure or endocrine therapy was administered as part of the first course of therapy. Diagnosed at autopsy.
10	A bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant--autologous.
12	Bone marrow transplant--allogenic.
20	Stem cell harvest and infusion. Umbilical cord stem cell transplant.
30	Endocrine surgery and/or endocrine radiation therapy.
40	Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12, or 20.)
82	Hematologic transplant and/or endocrine surgery/radiation was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of disease prior to administration, etc.).
85	Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy.
86	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but it was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it was not stated in patient record. Death certificate only.

Field 71) SURGICAL MARGINS (Surgical Margins of the Primary Site) (First Course of Therapy - Surgery)

Item Length: 1

Allowable Values: 0-3, 7-9

NAACCR Item #1320

Source of Information: *FORDS: Revised for 2010*

Description

Records the final status of the surgical margins after resection of the primary tumor.

Rationale

This item serves as a quality measure for pathology reports and is used for staging, and may be a prognostic factor in recurrence.

Instructions for Coding

- Record the margin status as it appears in the pathology report.
- Codes 0-3 are hierarchical; if two codes describe the margin status, use the numerically higher code.
- Code 7 if the pathology report indicates the margins could not be determined.
- If no surgery of the primary site was performed, code 8.
- Code 9 if the pathology report makes no mention of margins.
- For lymphomas (M-9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971) with a lymph node primary site (C77.0-C77.9), code 9.
- For an unknown or ill-defined primary site (C76.0-C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4, or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992), code 9.

Code	Label	Definition
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	It is unknown whether a surgical procedure to the primary site 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.

Example

Code	Reason
3	(C18-Colon) The pathology report from a colon resection describes the proximal margin as grossly involved with tumor (code 3) and the distal margin as microscopically involved (code 2). Code macroscopic involvement (code 3).

Field 72) SCOPE OF REGIONAL LYMPH NODE SURGERY (First Course of Therapy - Surgery)

Item Length: 1
 Allowable Values: 0-7, 9
 NAACCR Item #1292
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies 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.

Rationale

This data item can be used to compare and evaluate the extent of surgical treatment.

Instructions for Coding

- The scope of regional lymph node surgery is collected for each surgical event 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. Record the date of this surgical procedure in *Date of First Course of Treatment* (NAACCR Item #1270) and/or *Date of First Surgical Procedure* (NAACCR Item #1200) as appropriate.
- Codes 0-7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
- For intracranial and central nervous system primaries (C70.0-C70.9, C71.0-C71.9, C72.0-C72.9, C75.1-C75.3), code 9.
- For lymphomas (M-9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971) with a lymph node primary site (C77.0-C77.9), code 9.
- For an unknown or ill-defined primary (C76.0-76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992), 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* (NAACCR Item #1294).
- Refer to the current *AJCC Cancer Staging Manual* for site-specific identification of regional lymph nodes.
- If the procedure coded in this item was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care* (NAACCR Item #3270).

Code	Label	Definition
0	None	No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.
1	Biopsy or aspiration of regional lymph node, NOS	Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement of disease.
2	Sentinel lymph node biopsy	Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.
3	Number of regional nodes removed unknown or not stated; regional lymph nodes removed, NOS	Sampling or dissection of regional lymph node(s) and the number of nodes removed is unknown or not stated. The procedure is not specified as sentinel node biopsy.
4	1-3 regional lymph nodes removed	Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
5	4 or more regional lymph nodes removed	Sampling or dissection of regional lymph node(s) with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.

Code	Label	Definition
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 as 3, 4, or 5.
9	Unknown or not applicable	It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

Examples

Code	Reason
0	There was an attempt at regional lymph node dissection or sentinel lymph node dissection, but no lymph nodes were found in the pathologic specimen.
1	(C14.0-Pharynx) Aspiration of regional lymph node to confirm histology of widely metastatic disease.
2	(C44.5-Skin of Back) Patient has melanoma of the back. A sentinel lymph node dissection was done with the removal of one lymph node. This node was negative for disease.
3	(C61.9-Prostate) Bilateral pelvic lymph node dissection for prostate cancer.
6	(C50.3-Breast) Sentinel lymph node biopsy of right axilla, followed by right axillary lymph node dissection during the same surgical event.
9	(C34.9-Lung) Patient was admitted for radiation therapy following surgery for lung cancer. There is no documentation on the extent of surgery in patient record.

Note: One important use of registry data is the tracking of treatment patterns over time. In order to compare contemporary treatment with previously published treatment based on former codes, or to data unmodified from pre-1998 definitions, the ability to differentiate surgeries in which four or more regional lymph nodes are removed is desirable. However, it is *very important* to note that the distinction between codes 4 and 5 is made to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than 4 lymph nodes was not reflected in surgery codes. *It is not intended to reflect clinical significance* when applied to a particular surgical procedure. It is important to *avoid inferring, by data presentation or other methods, that one category is preferable to another within the intent of these items.*

Field 73) SURGERY OF OTHER REGIONAL SITE(S), OR DISTANT LYMPH NODES (Surgical Procedure/Other Site) (First Course of Therapy - Surgery)

Item Length: 1

Allowable Values: 0-5, 9

NAACCR Item #1294

Source of Information: *FORDS: Revised for 2010*

Description

Records the surgical removal of *distant lymph nodes* or other tissue(s) or organ(s) beyond the primary site.

Rationale

The removal of nonprimary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

Instructions for Coding

- If other tissue or organs are removed during primary site surgery that are not specifically defined by the site-specific *Surgical Procedure of the Primary Site* (NAACCR Item #1290 or #670) code, assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
- Assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
- Assign the highest numbered code that describes the surgical resection of *distant lymph node(s)*.
- Incidental removal of tissue or organs is not a “Surgical Procedure/Other Site.”
- *Surgical Procedure/Other Site* is collected for each surgical event even if surgery of the primary site was not performed.
- 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-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992).
- If the procedure coded in this item was provided to prolong a patient’s life by controlling symptoms to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care* (NAACCR Item #3270).

Code	Label	Definition
0	None	No surgical procedure of nonprimary site was performed. Diagnosed at autopsy.
1	Nonprimary surgical procedure performed	Nonprimary surgical resection to other site(s), unknown whether the site(s) is regional or distant.
2	Nonprimary surgical procedure to other regional sites	Resection of regional site.
3	Nonprimary surgical procedure to <i>distant lymph node(s)</i>	Resection of <i>distant lymph node(s)</i> .
4	Nonprimary surgical procedure to distant site	Resection of distant site.
5	Combination of codes	Any combination of surgical procedures 2, 3, or 4.
9	Unknown	It is unknown whether any surgical procedure of a nonprimary site was performed. Death certificate only.

Examples

Code	Reason
0	(C18.1--Colon) The incidental removal of the appendix during a surgical procedure to remove a primary malignancy in the right colon.
1	Surgical removal of metastatic lesion from liver; unknown primary.
2	(C18.3--Colon) Surgical ablation of solitary liver metastasis, hepatic flexure primary.
4	(C34.9--Lung) Removal of solitary brain metastasis.
5	(C21.0--Anus) Excision of solitary liver metastasis and one large hilar lymph node.

Field 74) IF NO CANCER DIRECTED SURGERY, REASON FOR NO SURGERY (Reason for No Surgery of Primary Site) (First Course of Therapy - Surgery)

Item Length: 1

Allowable Values: 0-2, 5-9

NAACCR Item #1340

Source of Information: *FORDS: Revised for 2010*

Description

Records the reason that no surgery was performed on the primary site.

Rationale

This data item provides information related to the quality of care and describes why primary site surgery was not performed.

Instructions for Coding

- If *Surgical Procedure of Primary Site* (NAACCR Item #1290) is coded 00, then record the reason based on documentation in the patient record.
- Code 1 if the treatment plan offered multiple options and the patient selected treatment that did not include surgery of the primary site, or if the option of “no treatment” was accepted by the patient.
- Code 1 if *Surgical Procedure of Primary Site* (NAACCR Item #1290) is coded 98.
- Code 7 if the patient refused recommended surgical treatment, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 8 if it is known that a physician recommended primary site surgery, but no further documentation is available yet to determine whether surgery was performed.
- Cases coded 8 should be followed and updated to a more definitive code as appropriate.
- Code 9 if the treatment plan offered multiple choices, but it is unknown which treatment, if any, was provided.

Code	Definition
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 (i.e., comorbid conditions, advanced age, progression of tumor prior to planned surgery, etc.).
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
6	Surgery of the primary site was not performed; it was recommended by the patient’s physician, but was not performed as part of the first-course therapy. No reason was noted in patient record.
7	Surgery of the primary site was not performed; 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 the patient record.
8	Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
9	It is unknown whether surgery of the primary site was recommended or performed. Diagnosed at autopsy or death certificate only.

Examples

Code	Reason
2	A patient with a primary tumor of the liver is not recommended for surgery due to advanced cirrhosis.
8	A patient is referred to another facility for recommended surgical resection of a gastric carcinoma, but further information from the facility to which the patient was referred is not available.

Field 75) PHYSICIAN-MANAGING LICENSE NUMBER

Item Length: 8
 Allowable Values: 0-9
 NAACCR Item #2460
 Source of Information: *OCISS*

Description

State issued medical license number for the physician who is responsible for the overall management of the patient during diagnosis and/or treatment of this cancer.

Instructions for Coding

- Use the physician’s state issued medical license number.
Note: License numbers for persons licensed by Ohio to practice medicine in Ohio can be found at <http://www.med.ohio.gov/>. Under PROFESSIONALS, click on “credential & research.”

Code	Definition
(fill spaces)	Physician’s state issued medical license number
99999999	Managing physician is unknown

Field 76) NPI--MANAGING PHYSICIAN

Item Length: 10
 Allowable Values: 0-9
 NAACCR Item #2465
 Source of Information: *OCISS*

Description

Identifies the physician who is responsible for the overall management of the patient during diagnosis and/or treatment of this cancer.

Rationale

The managing physician is responsible for the patient’s work-up, plans the treatment, and directs delivery of patient care. In most cases, the managing physician is responsible for AJCC staging.

Instructions for Coding

- THIS FIELD IS POPULATED BY OCISS.
- Record the 10-digit NPI for the physician responsible for managing the patient’s care.
- Check with the billing or health information departments to determine the physician’s NPI.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Do not update this item. Once the registry has designated a managing physician for the patient, this item should not be changed even if a different managing physician is assigned.

Code	Definition
(fill spaces)	10-digit NPI number for the managing physician.
(leave blank)	NPI for the managing physician is unknown or not available.

Field 77) PHYSICIAN--FOLLOW-UP LICENSE NUMBER

Item Length: 8
 Allowable Values: 0-9
 NAACCR Item #2470
 Source of Information: *OCISS*

Description

Records the state issued medical license number for the physician currently responsible for the patient’s medical care.

Rationale

The following physician is the first contact for obtaining information on a patient’s status and subsequent treatment. This information may be used for outcomes studies.

Instructions for Coding

- Use the physician’s state issued medical license number.
Note: License numbers for persons licensed by Ohio to practice medicine in Ohio can be found at <http://www.med.ohio.gov/>. Under PROFESSIONALS, click on “credential & research.”
- Change this data item when patient follow-up becomes the responsibility of another physician.

Code	Definition
(fill spaces)	Physician’s state issued medical license number.
99999999	Following physician is unknown.

Field 78) NPI--FOLLOWING PHYSICIAN

Item Length: 10
 Allowable Values: 0-9
 NAACCR Item #2475
 Source of Information: *OCISS*

Description

Records the NPI for the physician currently responsible for the patient’s medical care.

Rationale

The following physician is the first contact for obtaining information on a patient’s status and subsequent treatment. This information may be used for outcomes studies.

This field is the NPI equivalent of Field 77, Physician--Follow-Up License Number. For COC-approved programs, both are required during a period of transition.

Instructions for Coding

- THIS FIELD IS POPULATED BY OCISS.
- Record the 10-digit NPI for the physician currently responsible for managing the patient’s medical care.
- Check with the billing or health information departments to determine the physician’s NPI.
- Change this data item when patient follow-up becomes the responsibility of another physician.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Definition
(fill spaces)	10-digit NPI number for the managing physician.
(leave blank)	NPI for the managing physician is unknown or not available.

Field 79) PHYSICIAN--PRIMARY SURG LICENSE NUMBER

Item Length: 8
 Allowable Values: 0-9
 NAACCR Item #2480
 Source of Information: *OCISS*

Description

Records the state issued medical license number for the physician who performed the most definitive surgical procedure.

Rationale

Administrative, physician, and service referral reports are based on this data item.

Instructions for Coding

- Use the physician’s state issued medical license number.
Note: License numbers for persons licensed by Ohio to practice medicine in Ohio can be found at <http://www.med.ohio.gov/>. Under PROFESSIONALS, click on “credential & research.”
- Once the registry has designated a primary surgeon for the patient, the information should not be changed or updated even if the patient receives care from another surgeon.
- Do not update this data item.

Code	Definition
(fill spaces)	Physician’s state issued medical license number. <i>Note:</i> If the patient did not have surgery, use the code for the surgeon who performed any surgery or did a surgical consultation.
00000000	If the patient had no surgery and no surgical consultation.
88888888	If the physician who performed a surgical procedure was not a surgeon, i.e., radiation oncologist, diagnostic radiologist, or general practitioner.
99999999	The primary surgeon is unknown.

Field 80) NPI--PRIMARY SURGEON Item Length: 10
 Allowable Values: 0-9
 NAACCR Item #2485
 Source of Information: *OCISS*

Description

Identifies the physician who performed the most definitive surgical procedure.

Rationale

Administrative, physician, and service referral reports are based on this data item.

This field is the NPI equivalent of Field 79, Physician--Primary Surg License Number. For COC-approved programs, both are required during a period of transition.

Instructions for Coding

- THIS FIELD IS POPULATED BY OCISS.
- Record the 10-digit NPI for the physician who performed the most definitive surgical procedure.
- Check with the billing or health information departments to determine the physician's NPI.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Do not update this item. Once the registry has designated a primary surgeon for the patient, the information should not be changed or updated even if the patient receives care from another surgeon.

Code	Definition
(fill spaces)	10-digit NPI number for the primary surgeon.
(leave blank)	The patient did not have surgery. NPI for the primary surgeon is unknown or not available; or the physician who performed the surgical procedure was not a surgeon (i.e., general practitioner).

Field 81) PHYSICIAN 3 LICENSE NUMBER (Radiation Oncologist-Preferred)

Field 82) NPI – PHYSICIAN 3 (Radiation Oncologist-Preferred)

Field 83) PHYSICIAN 4 LICENSE NUMBER (Medical Oncologist-Preferred)

Field 84) NPI – PHYSICIAN 4 (Medical Oncologist-Preferred)

Data fields no longer collected, effective with cases diagnosed on or after January 1, 2010.

Field 85) CS TUMOR SIZE

Item Length: 3

Allowable Values: 000-995, 999

NAACCR Item #2800

Source of Information: *FORDS: Revised for 2010*

Description

Records the largest dimension, or the diameter of the **primary tumor** in millimeters.

Rationale

Tumor size at diagnosis is an independent prognostic indicator for many tumors and it is used by Collaborative Staging to derive some TNM-T codes.

Instructions for Coding

- Refer to site and histology-specific instructions in the current *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

Field 86) CS EXTENSION

Item Length: 2

Allowable Values: 00-80, 95, 99

NAACCR Item #2810

Source of Information: *FORDS: Revised for 2010*

Description

Identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. For certain sites such as ovary, discontinuous metastasis is coded in *CS Extension*.

Rationale

Tumor extension at diagnosis is a prognostic indicator used by Collaborative Staging to derive some TNM-T codes and some SEER Summary Stage codes.

Instructions for Coding

- Refer to site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

Field 87) CS TUMOR SIZE/EXTENSION EVALUATED

Item Length: 1

Allowable Values: 0-3, 5, 6, 8, 9

NAACCR Item #2820

Source of Information: *FORDS: Revised for 2010*

Description

Records how the codes for the two items *CS Tumor Size* (NAACCR Item #2800) and *CS Extension* (NAACCR Item #2810) were determined, based on the diagnostic methods employed.

Rationale

This item is used by Collaborative Staging to describe whether the staging basis for the TNM-T code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

Instructions for Coding

- Refer to site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

Field 87a) LYMPH-VASCULAR INVASION

Item Length: 1
 Allowable Values: 0, 1, 8, 9
 NAACCR Item #1182
 Source of Information: *FORDS: Revised for 2010*

Description

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.

Rationale

Lymph-vascular invasion is an indicator of prognosis. This field is used by the CS algorithm to map AJCC T for some primary sites.

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 that is not available, code from the pathology report or a physician’s statement, in that order of priority.
- Use code 1 if lymph-vascular is identified anywhere in a primary tumor specimen.
- Use code 0 if the pathology report indicates no lymph-vascular invasion was found.
- Use code 8 if no pathologic examination of primary site tissue was performed.
- Use code 8 for histologies 9590-9922.
- Use code 9 if primary site tissue was sent to pathology, but no report based on it is available (the report cannot be found or surgery was at a different facility and the information was not provided to the reporting facility).
- Use code 9 if the pathology report indicates that the presence of lymph-vascular invasion could not be determined.

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

Field 88) CS LYMPH NODES

Item Length: 2

Allowable Values: 0-80, 90

NAACCR Item #2830

Source of Information: *FORDS: Revised for 2010*

Description

Identifies the regional lymph nodes involved with cancer at the time of diagnosis.

Rationale

The involvement of specific regional lymph nodes is a prognostic indicator used by Collaborative Staging to derive some TNM-N codes and SEER Summary Stage codes.

Instructions for Coding

- Refer to site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

Field 89) CS REGIONAL LYMPH NODES EVALUATED

Item Length: 1

Allowable Values: 0-3, 5, 6, 8, 9

NAACCR Item #2840

Source of Information: *FORDS: Revised for 2010*

Description

Records how the codes for *CS Lymph Nodes* (NAACCR Item #2830) was determined, based on the diagnostic methods employed.

Rationale

This data item is used by Collaborative Staging to describe whether the staging basis for the TNM-N code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

Instructions for Coding

- Refer to site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

Field 90) CS NUMBER OF REGIONAL LYMPH NODES POSITIVE

Item Length: 2

Allowable Values: 00-99

NAACCR Item #820

Source of Information: *FORDS: Revised for 2010*

Description

Records the exact number of regional lymph nodes examined by the pathologist and found to contain metastases. Beginning with cases diagnosed on or after January 1, 2004, this item became a component of the Collaborative Staging System (CS).

Rationale

This data item is necessary for pathologic staging, and it serves as a quality measure for pathology reports and the extent of the surgical evaluation and treatment of the patient.

Instructions for Coding

- Refer to the site/histology-specific instructions in the current *Collaborative Staging Manual* for codes and Instructions for Coding.

Field 91) CS NUMBER OF REGIONAL LYMPH NODES EXAMINED

Item Length: 2

Allowable Values: 00-90, 95-99

NAACCR Item #830

Source of Information: *FORDS: Revised for 2010*

Description

Records the total number of regional lymph nodes that were removed and examined by the pathologist. Beginning with cases diagnosed on or after January 1, 2004, this item became a component of the Collaborative Staging System (CS).

Rationale

This data item serves as a quality measure of the pathologic and surgical evaluation and treatment of the patient.

Instructions for Coding

- Refer to the site/histology-specific instructions in the current *Collaborative Staging Manual* for codes and Instructions for Coding.

Field 92) CS METASTASIS AT DIAGNOSIS

Item Length: 2

Allowable Values: 00, 10, 40, 50, 99

NAACCR Item #2850

Source of Information: *FORDS: Revised for 2010*

Description

Identifies the distant site(s) of metastatic involvement at time of diagnosis.

Rationale

The presence of metastatic disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

Field 93) CS METASTASIS EVALUATED

Item Length: 1

Allowable Values: 0-3, 5, 6, 8, 9

NAACCR Item #2860

Source of Information: *FORDS: Revised for 2010*

Description

Records how the codes for *CS Mets at Dx* (NAACCR Item #2850) was determined based on the diagnostic methods employed.

Rationale

This data item is used by Collaborative Staging to describe whether the staging basis for the TNM-M code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

Field 94) CS SITE-SPECIFIC FACTOR 1

Item Length: 3
 Allowable Values: 000-999
 NAACCR Item #2880
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 1 (SSF1) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF1s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 1
Head and Neck*	See note after this table	8000–8576, 8940–8950, 8980–8981	Size of Lymph Nodes
Mucosal Melanoma**	See note after this table	8720-8790	Size of Lymph Nodes
Esophagus	C15.0-5,8,9	8000-8576, 8940-8950, 8980-8981	Clinical Assessment of Regional Lymph Nodes
EsophagusGE Junction	C16.0-2	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Clinical Assessment of Regional Lymph Nodes
Stomach	C16.1-6,8-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8990	Clinical Assessment of Regional Lymph Nodes
NETStomach	C16.0-6,8-9	8153, 8240-8242, 8246, 8249	Clinical Assessment of Regional Lymph Nodes
SmallIntestine	C17.0-3,8-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Carcinoembryonic Antigen (CEA)
Colon	C18.0,2-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Carcinoembryonic Antigen (CEA)
Appendix	C18.1	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Carcinoembryonic Antigen (CEA)
Rectum	C19.9; C20.9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Carcinoembryonic Antigen (CEA)
Liver	C22.0-1	8170-8175	Alpha Fetoprotein (AFP) Interpretation
BileDucts Intrahepat	C22.0-1	8160-8161, 8180	Alpha Fetoprotein (AFP) Interpretation

Lung	C34.0-3,8-9	8000-8576, 8940-8950, 8980-8981	Separate Tumor Nodules / Ipsilateral Lung
HeartMediastinum	C38.0-3,8	8800-8936, 8940-9136, 9141-9582	Grade for Sarcomas
Pleura	C38.4	9050-9053	Pleural Effusion
Skin	C44.0,2-9	8000-8246, 8248-8576, 8940-8950, 8980-8981	Measured Thickness (Depth)
MelanomaSkin	C44.0-9; C51.0-2, 8-9; C60.0-2,8-9; C63.2	8270-8290	Measured Thickness (Depth), Breslow's Measurement
MerkelCellSkin	C44.0,2-9	8247	Measured Thickness (Depth)
MerkelCellVulva	C51.0-2,8-9	8247	Measured Thickness (Depth)
MerkelCellPenis	C60.0-2,8-9	8247	Measured Thickness (Depth)
MerkelCellScrotum	C63.2	8247	Measured Thickness (Depth)
SoftTissue	C47.0-6,8-9; C49.0-6,8-9	8800-8936, 8940-9136, 9141-9582	Grade for Sarcomas
Retroperitoneum	C48.0	8800-8921, 8940-9136, 9141-9582	Grade for Sarcomas
Peritoneum	C48.0-2,8	8800-8921, 8940-9055, 9120-9136, 9141-9582	Grade for Sarcomas
Peritoneum FemaleGenital	C48.0-2,8 (Females Only)	8000-8576, 8590-8671, 8930-8934, 8940-9110	Carbohydrate Antigen 125 (CA 125)
Breast	C50.0-6, 8-9	8000-8576, 8940-8950, 8980-8981, 9020	Estrogen Receptor Assay (ERA)
Vagina	C52.9	8000-8576, 8800-8801, 8940-8950, 8980-8981	FIGO Stage
Cervix	C53.0-1, 8-9	8000-8576, 8940-8950, 8980-8981	FIGO Stage
Corpus Adenosarcoma	C54.0-3, 8-9; C55.9	8933	FIGO Stage
Corpus Carcinoma	C54.0-3, 8-9; C55.9	8000-8790, 8980-8981, 9700-9701	FIGO Stage
CorpusSarcoma	C54.0-3, 8-9; C55.9	8890-8898, 8930-8931	FIGO Stage
Ovary	C56.9	8000-8576, 8590-8671, 8930-9110	Carbohydrate Antigen 125 (CA 125)
Fallopian Tube	C57.0	8000-8576, 8940-8950, 8980-8981	FIGO Stage
Placenta	C58.9	9100-9105	Prognostic Scoring Index
Prostate	C61.9	8000-8110, 8140-8576, 8940-8950, 8980-8981	Prostate Specific Antigen (PSA) Lab Value
Scrotum	C63.2	8000-8246, 8248-8576, 8940-8950, 8980-8981	Measured Thickness (Depth)
Kidney Parenchyma	C64.9	8000-8576, 8940-8950, 8980-8981	Invasion Beyond Capsule
KidneyRenal Pelvis	C65.9; C66.9	8000-8576, 8940-8950, 8980-8981	WHO/ISUP Grade
Bladder	C67.0-9	8000-8576, 8940-8950, 8980-8981	WHO/ISUP Grade
Urethra	C68.0	8000-8576, 8940-8950, 8980-8981	WHO/ISUP Grade
Retinoblastoma	C69.0-5,8-9	9510-9514	Extension Evaluated at Enucleation

Lymphoma OcularAdnexa	C44.1; C69.0,5,6	9590-9699, 9702-9738, 9811-9818, 9820-9837	Associated with HIV/AIDS
Conjunctiva	C69.0	8000-8576, 8940-8950, 8980-8981	Tumor Size
Melanoma Conjunctiva	C69.0	8720-8790	Measured Thickness (Depth)
Brain	C70.0, C71.0-9	8000, 8680-9136,9141-9582	WHO Grade Classification
CNSOther	C70.1, 9; C72.0-5,8-9	8000, 8680-9136,9141-9582	WHO Grade Classification
Thyroid	C73.9	8000-8576, 8940-8950, 8980-8981	Solitary vs. Multifocal Tumor
IntracranialGland	C75.1-3	8000, 8680-9136,9141-9582	WHO Grade Classification
Lymphoma	C00.0-C68.9; C70.0-C80.9	9590-9699, 9702-9729, 9735, 9737-9738	Associated with HIV/AIDS
MycosisFungoides	C44.0-C44.9, C51.0-C51.2, C51.8-C51.9, C60.0-C60.2, C60.8-C60.9, C63.2	9700-9701	Peripheral Blood Involvement
Kaposi Sarcoma	M-9140		Associated with HIV/AIDS
HemeRetic	M-9731-9734, 9740-9742, 9750-9758, 9760-9762, 9764-9769, 9800-9801, 9805, 9820, 9826, 9831-9837, 9840, 9860-9861, 9863, 9866-9867, 9870-9876, 9891, 9895-9897, 9910, 9920, 9930-9931, 9940, 9945-9946, 9948, 9950, 9960-9964, 9970, 9975, 9980, 9982-9987, 9989. M-9823 and 9827 for C42.0, C42.1, or C42.4 <i>only</i> . See <i>Collaborative Stage</i> for site detail.		JAK-2

* Head and Neck: C00.0-6,8,9; C01 9; C02.0-4,8,9; C03.0-1,9; C04.0-1,8,9; C05.0-2,8,9; C06.0-2,8,9; C07.9; C08.0-1,8,9; C09.0-1,8,9; C10.0-4,8,9; C11.0; C30.0-1; C31.0-3,8-9; C32.0-3,8,9

** Mucosal Melanoma: C00.0-6,8-9; C01.9; C02.0-4,8-9; C03.0-1,9; C04.0-1,8-9; C05.0-2,8-9; C06.0-2,8-9; C09.0-1,8-9; C10.0-4,8-9; C11.0-3,8-9; C12.9; C13.2,8-9; C14.0,2,8; C30.0,2,8-9; C31.0-3,8-9; C32.0-3,8-9

Field 95) CS SITE-SPECIFIC FACTOR 2

Item Length: 3
 Allowable Values: 000-999
 NAACCR Item #2890
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 2 (SSF2) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF2s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 2
Colon	C18.0,2-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Clinical Assessment of Regional Lymph Nodes
NETColon	C18.0,2-9	8153, 8240-8242, 8246, 8249	Clinical Assessment of Regional Lymph Nodes
Appendix	C18.1	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Clinical Assessment of Regional Lymph Nodes
CarcinoidAppendix	C18.1	8153, 8240-8242, 8246, 8249	Clinical Assessment of Regional Lymph Nodes
Rectum	C19.9; C20.9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Clinical Assessment of Regional Lymph Nodes
NETRectum	C19.9; C20.9	8153, 8240-8242, 8246, 8249	Clinical Assessment of Regional Lymph Nodes
Small Intestine	C17.0-3,8-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Clinical Assessment of Regional Lymph Nodes
Liver	C22.0-1	8170-8175	Fibrosis Score
BileDucts Intrahepat	C22.0-1	8160-8161, 8180	Fibrosis Score
Lung	C34.0-3,8-9	8000-8576, 8940-8950, 8980-8981	Visceral Pleural Invasion (VPI)/Elastic Layer
Pleura	C38.4	9050-9053	Histologic Subtype
MelanomaSkin	C44.0-9; C51.0-2, 8-9; C60.0-2,8-9; C63.2	8270-8290	Ulceration
Peritoneum FemaleGenital	C48.0-2,8 (Females Only)	8000-8576, 8590-8671, 8930-8934, 8940-9110	FIGO Stage

Breast	C50.0-6, 8-9	8000-8576, 8940-8950, 8980-8981, 9020	Progesterone Receptor Assay (PRA)
Vulva	C51.0-2,8-9	8000-8246, 8248-8576, 8940-8950, 8980-8981	FIGO Stage
Vagina	C52.9	8000-8576, 8800-8801, 8940-8950, 8980-8981	Pelvic Nodal Status
Corpus Adenosarcoma	C54.0-3, 8-9; C55.9	8933	Peritoneal Cytology
Corpus Carcinoma	C54.0-3, 8-9; C55.9	8000-8790, 8980-8981, 9700-9701	Peritoneal Cytology
CorpusSarcoma	C54.0-3, 8-9; C55.9	8890-8898, 8930-8931	Peritoneal Cytology
Ovary	C56.9	8000-8576, 8590-8671, 8930-9110	FIGO Stage
Placenta	C58.9	9100-9105	FIGO Stage
Prostate	C61.9	8000-8110, 8140-8576, 8940-8950, 8980-8981	Prostatic Specific Antigen (PSA) Interpretation
Kidney Parenchyma	C64.9	8000-8576, 8940-8950, 8980-8981	Vein Involvement
KidneyRenal Pelvis	C65.9; C66.9	8000-8576, 8940-8950, 8980-8981	Depth of Renal Parenchymal Invasion
Bladder	C67.0-9	8000-8576, 8940-8950, 8980-8981	Size of Metastasis in Lymph Nodes
Lymphoma OcularAdnexa	C44.1; C69.0,5,6	9590-9699, 9702-9738, 9811-9818, 9820-9837	Systemic Symptoms at Diagnosis
Melanoma Conjunctiva	C69.0	8720-8790	Quadrants
Melanoma Choroid	C69.3	8720-8790	Measured Basal Diameter
Melanoma Ciliary Body	C69.4	8720-8790	Measured Basal Diameter
Lymphoma	C00.0-C68.9; C70.0-C80.9	9590-9699, 9702-9729, 9735, 9737-9738	Systemic Symptoms at Diagnosis

Field 96) CS SITE-SPECIFIC FACTOR 3

Item Length: 3
 Allowable Values: 000-999
 NAACCR Item #2900
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility’s records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 3 (SSF3) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF3s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 3
Head and Neck*	See note after this table	8000–8576, 8940–8950, 8980–8981	Levels I-III Lymph Nodes for Head and Neck
Mucosal Melanoma**	See note after this table	8720-8790	Levels I-III Lymph Nodes for Head and Neck
Colon	C18.0,2-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Carcinoembryonic Antigen (CEA) Lab Value
Appendix	C18.1	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Carcinoembryonic Antigen (CEA) Lab Value
Rectum	C19.9; C20.9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Carcinoembryonic Antigen (CEA) Lab Value
Small Intestine	C17.0-3,8-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Carcinoembryonic Antigen (CEA) Lab Value
Liver	C22.0-1	8170-8175	Alpha Fetoprotein (AFP) Interpretation Lab Value
HeartMediastinum	C38.0-3,8	8800-8936, 8940-9136, 9141-9582	Bone Invasion
Bone	C40.0-3,8-9;C41.0-4,8-9	8800-9136,9142-9582	% Necrosis Post-Neoadjuvant Chemotherapy
SkinEyelid	C44.1	8000-8576, 8940-8950, 8980-8981	Clinical Status of Lymph Nodes
MelanomaSkin	C44.0-9; C51.0-2, 8-9; C60.0-2,8-9; C63.2	8270-8290	Clinical Status of Lymph Nodes Mets
MerkelCellSkin	C44.0,2-9	8247	Clinical Status of Lymph Nodes Mets

MerkelCellVulva	C51.0-2,8-9	8247	Clinical Status of Lymph Nodes Mets
MerkelCellPenis	C60.0-2,8-9	8247	Clinical Status of Lymph Nodes Mets
MerkelCellScrotum	C63.2	8247	Clinical Status of Lymph Nodes Mets
SoftTissue	C47.0-6,8-9; C49.0-6,8-9	8800-8820, 8823-8935, 8940-9136, 9142-9582	Bone Invasion
Peritoneum FemaleGenital	C48.0-2,8 (Females Only)	8000-8576, 8590-8671, 8930-8934, 8940-9110	Residual Tumor Status and Size After Primary Cytoreduction Surgery
Breast	C50.0-6, 8-9	8000-8576, 8940-8950, 8980-8981, 9020	Number of Positive Ipsilateral Level I-II Axillary Lymph Nodes
Vagina	C52.9	8000-8576, 8800-8801, 8940-8950, 8980-8981	Assessment Method of Nodal Pelvic Status
Corpus Adenosarcoma	C54.0-3, 8-9; C55.9	8933	Number of Positive Pelvic Lymph Nodes
Corpus Carcinoma	C54.0-3, 8-9; C55.9	8000-8790, 8980-8981, 9700-9701	Number of Positive Pelvic Lymph Nodes
CorpusSarcoma	C54.0-3, 8-9; C55.9	8890-8898, 8930-8931	Number of Positive Pelvic Lymph Nodes
Ovary	C56.9	8000-8576, 8590-8671, 8930-9110	Residual Tumor Status and Size After Primary Cytoreduction Surgery
Prostate	C61.9	8000-8110, 8140-8576, 8940-8950, 8980-8981	CS Extension – Pathologic Extension
Kidney Parenchyma	C64.9	8000-8576, 8940-8950, 8980-8981	Ipsilateral Adrenal Gland Involvement
Bladder	C67.0-9	8000-8576, 8940-8950, 8980-8981	Extranodal Extension of Regional Lymph Nodes
Lymphoma OcularAdnexa	C44.1; C69.0,5,6	9590-9699, 9702-9738, 9811-9818, 9820-9837	International Prognostic Index (IPI)
Melanoma Choroid	C69.3	8720-8790	Measured Thickness (Depth)
MelanomaCiliary Body	C69.4	8720-8790	Measured Thickness (Depth)
MelanomaIris	C69.4 (Iris)	8720-8790	Measured Thickness (Depth)
Lymphoma	C00.0-C68.9; C70.0- C80.9	9590-9699, 9702-9729, 9735, 9737-9738	International Prognostic Index (IPI)

* Head and Neck: C00.0-6,8,9; C01.9; C02.0-4,8,9; C03.0-1,9; C04.0-1,8,9; C05.0-2,8,9; C06.0-2,8,9; C07.9; C08.0-1,8,9; C09.0-1,8,9; C10.0-4,8,9; C11.0; C30.0-1; C31.0-3,8-9; C32.0-3,8,9

** Mucosal Melanoma: C00.0-6,8-9; C01.9; C02.0-4,8-9; C03.0-1,9; C04.0-1,8-9; C05.0-2,8-9; C06.0-2,8-9; C09.0-1,8-9; C10.0-4,8-9; C11.0-3,8-9; C12.9; C13.2,8-9; C14.0,2,8; C30.0,2,8-9; C31.0-3,8-9; C32.0-3,8-9

Field 97) CS SITE-SPECIFIC FACTOR 4

Item Length: 3
 Allowable Values: 000-999
 NAACCR Item #2910
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility’s records. However, if that information is obtained along with other materials from another source, it may be used.
- The Prostate SSF4 (Prostate Apex Involvement) does not show on this table, because it is considered obsolete in 2010. However, it is required for cases diagnosed through 2009, as it was required in CSv1, even if it is abstracted in CSv2.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 4 (SSF4) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF4s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 4
Head and Neck*	See note after this table	8000–8576, 8940–8950, 8980–8981	Levels IV-V and Retropharyngeal Lymph Nodes for Head and Neck
Mucosal Melanoma**	See note after this table	8720-8790	Levels IV-V and Retropharyngeal Lymph Nodes for Head and Neck
Colon	C18.0,2-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Tumor Deposits
Rectum	C19.9; C20.9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Tumor Deposits
Liver	C22.0-1	8170-8175	Creatinine Value
MelanomaSkin	C44.0-9; C51.0-2, 8-9; C60.0-2,8-9; C63.2	8270-8290	LDH
Breast	C50.0-6, 8-9	8000-8576, 8940-8950, 8980-8981, 9020	Immunohistochemistry (IHC) of Regional Lymph Nodes
Vagina	C52.9	8000-8576, 8800-8801, 8940-8950, 8980-8981	Para-Aortic Nodal Status
Corpus Adenosarcoma	C54.0-3, 8-9; C55.9	8933	Number of Examined Pelvic Nodes
Corpus Carcinoma	C54.0-3, 8-9; C55.9	8000-8790, 8980-8981, 9700-9701	Number of Examined Pelvic Nodes
CorpusSarcoma	C54.0-3, 8-9; C55.9	8890-8898, 8930-8931	Number of Examined Pelvic Nodes
Fallopian Tube	C57.0	8000-8576, 8940-8950, 8980-8981	Number of Positive Pelvic Nodes

Testis	C62.0-1,9	8000-8576, 8590-8593, 8940-8950, 8980-8981, 9060-9090, 9100-9105	Radical Orchiectomy Performed
Kidney Parenchyma	C64.9	8000-8576, 8940-8950, 8980-8981	Sarcomatoid Features
Melanoma Choroid	C69.3	8720-8790	Size of Largest Metastasis
MelanomaIris	C69.4	8720-8790	Size of Largest Metastasis
MelanomaCiliary Body	C69.4	8720-8790	Size of Largest Metastasis
LacrimalGland	C69.5	8000-8576, 8940-8950, 8980-8981	Perineural Invasion
Brain	C70.0, C71.0-9	8000, 8680-9136, 9141-9582	MGMT – Methylation of MGMT
CNSOther	C70.1,9; C72.0-5,8-9	8000, 8680-9136, 9141-9582	MGMT – Methylation of MGMT

* Head and Neck: C00.0-6,8,9; C01.9; C02.0-4,8,9; C03.0-1,9; C04.0-1,8,9; C05.0-2,8,9; C06.0-2,8,9; C07.9; C08.0-1,8,9; C09.0-1,8,9; C10.0-4,8,9; C11.0; C30.0-1; C31.0-3,8-9; C32.0-3,8,9

** Mucosal Melanoma: C00.0-6,8-9; C01.9; C02.0-4,8-9; C03.0-1,9; C04.0-1,8-9; C05.0-2,8-9; C06.0-2,8-9; C09.0-1,8-9; C10.0-4,8-9; C11.0-3,8-9; C12.9; C13.2,8-9; C14.0,2,8; C30.0,2,8-9; C31.0-3,8-9; C32.0-3,8-9

Field 98) CS SITE-SPECIFIC FACTOR 5

Item Length: 3

Allowable Values: 000-999

NAACCR Item #2920

Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 5 (SSF5) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF5s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 5
Head and Neck*	See note after this table	8000–8576, 8940–8950, 8980–8981	Levels VI-VII and Facial Lymph Nodes of Head and Neck
Mucosal Melanoma**	See note after this table	8720-8790	Levels VI-VII and Facial Lymph Nodes of Head and Neck
Liver	C22.0-1	8170-8175	Creatinine Unit of Measure
NETAmpulla	C24.1	8153, 8240-8242, 8246, 8249	Serum Chromogranin A (CgA) Lab Value
MelanomaSkin	C44.0-9; C51.0-2, 8-9; C60.0-2,8-9; C63.2	8270-8290	LDH Value
GIST Peritoneum	C48.0-2,8	8935-8936	Mitotic Count
Breast	C50.0-6, 8-9	8000-8576, 8940-8950, 8980-8981, 9020	Molecular Studies of Regional Lymph Nodes
Vagina	C52.9	8000-8576, 8800-8801, 8940-8950, 8980-8981	Assessment of Para-Aortic Nodal Status
Corpus Adenosarcoma	C54.0-3, 8-9; C55.9	8933	Number of Positive Para-Aortic Lymph Nodes
Corpus Carcinoma	C54.0-3, 8-9; C55.9	8000-8790, 8980-8981, 9700-9701	Number of Positive Para-Aortic Lymph Nodes
CorpusSarcoma	C54.0-3, 8-9; C55.9	8890-8898, 8930-8931	Number of Positive Para-Aortic Lymph Nodes
Fallopian Tube	C57.0	8000-8576, 8940-8950, 8980-8981	Number of Examined Pelvic Lymph Nodes
Testis	C62.0-1,9	8000-8576, 8590-8593, 8940-8950, 8980-8981, 9060-9090, 9100-9105	Size of Metastasis in Lymph Nodes
Melanoma Choroid	C69.3	8720-8790	Chromosome 3 Status
MelanomaIris	C69.4	8720-8790	Chromosome 3 Status

MelanomaCiliary Body	C69.4	8720-8790	Chromosome 3 Status
Brain	C70.0, C71.0-9	8000, 8680-9136, 9141-9582	Gene Deletions 1p
CNSOther	C70.1,9; C72.0-5,8-9	8000, 8680-9136, 9141-9582	Gene Deletions 1p

* Head and Neck: C00.0-6,8,9; C01.9; C02.0-4,8,9; C03.0-1,9; C04.0-1,8,9; C05.0-2,8,9; C06.0-2,8,9; C07.9; C08.0-1,8,9; C09.0-1,8,9; C10.0-4,8,9; C11.0; C30.0-1; C31.0-3,8-9; C32.0-3,8,9

** Mucosal Melanoma: C00.0-6,8-9; C01.9; C02.0-4,8-9; C03.0-1,9; C04.0-1,8-9; C05.0-2,8-9; C06.0-2,8-9; C09.0-1,8-9; C10.0-4,8-9; C11.0-3,8-9; C12.9; C13.2,8-9; C14.0,2,8; C30.0,2,8-9; C31.0-3,8-9; C32.0-3,8-9

Field 99) CS SITE-SPECIFIC FACTOR 6

Item Length: 3

Allowable Values: 000-999

NAACCR Item #2930

Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 6 (SSF6) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF6s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 6
Head and Neck*	See note after this table	8000–8576, 8940–8950, 8980–8981	Parapharyngeal, Parotid, and Suboccipital/Retroauricular Lymph Nodes
Mucosal Melanoma**	See note after this table	8720-8790	Parapharyngeal, Parotid, and Suboccipital/Retroauricular Lymph Nodes
GISTEsophagus	C15.0-5,8-9	8935-8936	Mitotic Count
GISTStomach	C16.0-6,8-9	8935-8936	Mitotic Count
GISTSmall Intestine	C17.0-3,8-9	8935-8936	Mitotic Count
Colon	C18.0,2-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Circumferential Resection Margin (CRM)
Rectum	C19.9; C20.9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Circumferential Resection Margin (CRM)
Liver	C22.0-1	8170-8175	Total Bilirubin Value
NETAmpulla	C24.1	8153, 8240-8242, 8246, 8249	Urinary 5-HIAA Lab Value
SkinEyelid	C44.1	8000-8576, 8940-8950, 8980-8981	Perineural Invasion
MelanomaSkin	C44.0-9; C51.0-2, 8-9; C60.0-2,8-9; C63.2	8270-8290	LDH Upper Limits of Normal
GISTPeritoneum	C48.0-2,8	8935-8936	KIT Immunohistochemistry (IHC)
Breast	C50.0-6, 8-9	8000-8576, 8940-8950, 8980-8981, 9020	Size of Tumor – Invasive Component
Vagina	C52.9	8000-8576, 8800-8801, 8940-8950, 8980-8981	Distant (mediastinal, scalene) Node Status
Corpus Adenosarcoma	C54.0-3, 8-9; C55.9	8933	Number of Examined Para-Aortic Lymph Nodes
Corpus Carcinoma	C54.0-3, 8-9; C55.9	8000-8790, 8980-8981, 9700-9701	Number of Examined Para-Aortic Lymph Nodes

CorpusSarcoma	C54.0-3, 8-9; C55.9	8890-8898, 8930-8931	Number of Examined Para-Aortic Lymph Nodes
Fallopian Tube	C57.0	8000-8576, 8940-8950, 8980-8981	Number of Positive Para-Aortic Lymph Nodes
Testis	C62.0-1,9	8000-8576, 8590-8593, 8940-8950, 8980-8981, 9060-9090, 9100-9105	Preorchietomy Alpha Fetoprotein (AFP) Lab Value
Kidney Parenchyma	C64.9	8000-8576, 8940-8950, 8980-8981	Fuhrman Grade
Lymphoma OcularAdnexa	C44.1; C69.0,5,6	9590-9699, 9702-9738, 9811-9818, 9820-9837	LDH Interpretation
Melanoma Choroid	C69.3	8720-8790	Chromosome 6p Status
MelanomaIris	C69.4	8720-8790	Chromosome 6p Status
MelanomaCiliary Body	C69.4	8720-8790	Chromosome 6p Status
LacrimalGland	C69.5	8000-8576, 8940-8950, 8980-8981	Adenoid Cystic Carcinoma – Presence of Basaloid Pattern
Brain	C70.0, C71.0-9	8000, 8680-9136, 9141-9582	Gene Deletions 19q
CNSOther	C70.1,9; C72.0-5,8-9	8000, 8680-9136, 9141-9582	Gene Deletions 19q

* Head and Neck: C00.0-6,8,9; C01.9; C02.0-4,8,9; C03.0-1,9; C04.0-1,8,9; C05.0-2,8,9; C06.0-2,8,9; C07.9; C08.0-1,8,9; C09.0-1,8,9; C10.0-4,8,9; C11.0; C30.0-1; C31.0-3,8-9; C32.0-3,8,9

** Mucosal Melanoma: C00.0-6,8-9; C01.9; C02.0-4,8-9; C03.0-1,9; C04.0-1,8-9; C05.0-2,8-9; C06.0-2,8-9; C09.0-1,8-9; C10.0-4,8-9; C11.0-3,8-9; C12.9; C13.2,8-9; C14.0,2,8; C30.0,2,8-9; C31.0-3,8-9; C32.0-3,8-9

Field 99a) CS SITE-SPECIFIC FACTOR 7

Item Length: 3
 Allowable Values: 000-999
 NAACCR Item #2861
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 7 (SSF7) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF7s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 7
GISTEsophagus	C15.0-5,8-9	8935-8936	KIT Immunohistochemistry (IHC)
GISTStomach	C16.0-6,8-9	8935-8936	KIT Immunohistochemistry (IHC)
GISTSmall Intestine	C17.0-3,8-9	8935-8936	KIT Immunohistochemistry (IHC)
Liver	C22.0-1	8170-8175	Total Bilirubin Unit of Measure
MelanomaSkin	C44.0-9; C51.0-2, 8-9; C60.0-2,8-9; C63.2	8270-8290	Primary Tumor Mitotic Count/Rate
Breast	C50.0-6, 8-9	8000-8576, 8940-8950, 8980-8981, 9020	Nottingham or Bloom-Richardson Score/Grade
Vagina	C52.9	8000-8576, 8800-8801, 8940-8950, 8980-8981	Assessment Method of Distant (mediastinal, scalene) Node Status
Fallopian Tube	C57.0	8000-8576, 8940-8950, 8980-8981	Number of Examined Para-Aortic Lymph Nodes
Prostate	C61.9	8000-8110, 8140-8576, 8940-8950, 8980-8981	Gleason Primary and Secondary Pattern Value on Needle Core Biopsy/TURP
Testis	C62.0-1,9	8000-8576, 8590-8593, 8940-8950, 8980-8981, 9060-9090, 9100-9105	Preorchietomy Alpha Fetoprotein (AFP) Interpretation
Melanoma Choroid	C69.3	8720-8790	Chromosome 8q Status
MelanomaIris	C69.4	8720-8790	Chromosome 8q Status
MelanomaCiliary Body	C69.4	8720-8790	Chromosome 8q Status

Field 99b) CS SITE-SPECIFIC FACTOR 8

Item Length: 3
 Allowable Values: 000-999
 NAACCR Item #2862
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 8 (SSF8) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF8s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 8
Colon	C18.0,2-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Perineural Invasion
Rectum	C19.9; C20.9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Perineural Invasion
Liver	C22.0-1	8170-8175	International Normalized Ratio for Prothrombin Time (INR)
SkinEyelid	C44.1	8000-8576, 8940-8950, 8980-8981	Pagetoid Spread
Breast	C50.0-6, 8-9	8000-8576, 8940-8950, 8980-8981, 9020	HER2: IHC Test Lab Value
Prostate	C61.9	8000-8110, 8140-8576, 8940-8950, 8980-8981	Gleason Score on Needle Core Biopsy/TURP
Testis	C62.0-1,9	8000-8576, 8590-8593, 8940-8950, 8980-8981, 9060-9090, 9100-9105	Preorchietomy Human Chorionic Gonadotropin (hCG) Lab Value
Kidney Parenchyma	C64.9	8000-8576, 8940-8950, 8980-8981	Extranodal Extension of Regional Lymph Nodes
LacrimalGland	C69.5	8000-8576, 8940-8950, 8980-8981	Orbital Bone

Field 99c) CS SITE-SPECIFIC FACTOR 9

Item Length: 3
 Allowable Values: 000-999
 NAACCR Item #2863
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 9 (SSF9) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF9s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 9
Head and Neck*	See note after this table	8000–8576, 8940–8950, 8980–8981	Extracapsular Extension Pathologically, Lymph Nodes for Head and Neck
Mucosal Melanoma**	See note after this table	8720-8790	Extracapsular Extension Pathologically, Lymph Nodes for Head and Neck
Colon	C18.0,2-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	KRAS
Rectum	C19.9; C20.9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	KRAS
Breast	C50.0-6, 8-9	8000-8576, 8940-8950, 8980-8981, 9020	HER2: IHC Test Interpretation
Prostate	C61.9	8000-8110, 8140-8576, 8940-8950, 8980-8981	Gleason Primary Pattern and Secondary Pattern Value on Prostatectomy/Autopsy
Testis	C62.0-1,9	8000-8576, 8590-8593, 8940-8950, 8980-8981, 9060-9090, 9100-9105	Preorchietomy Human Chorionic Gonadotropin (hCG) Interpretation
Melanoma Choroid	C69.3	8720-8790	Mitotic Count
MelanomaIris	C69.4	8720-8790	Mitotic Count
MelanomaCiliary Body	C69.4	8720-8790	Mitotic Count

* Head and Neck: C00.0-6,8,9; C01.9; C02.0-4,8,9; C03.0-1,9; C04.0-1,8,9; C05.0-2,8,9; C06.0-2,8,9; C07.9; C08.0-1,8,9; C09.0-1,8,9; C10.0-4,8,9; C11.0; C30.0-1; C31.0-3,8-9; C32.0-3,8,9

** Mucosal Melanoma: C00.0-6,8-9; C01.9; C02.0-4,8-9; C03.0-1,9; C04.0-1,8-9; C05.0-2,8-9; C06.0-2,8-9; C09.0-1,8-9; C10.0-4,8-9; C11.0-3,8-9; C12.9; C13.2,8-9; C14.0,2,8; C30.0,2,8-9; C31.0-3,8-9; C32.0-3,8-9

Field 99d) CS SITE-SPECIFIC FACTOR 10

Item Length: 3
 Allowable Values: 000-999
 NAACCR Item #2864
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 10 (SSF10) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF10s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 10
TongueBase	C01.9, C02.4	8000-8576, 8940-8950, 8980-8981	HPV (Human Papilloma Virus) Status
PalateSoft	C05.1-2	8000-8576, 8940-8950, 8980-8981	HPV (Human Papilloma Virus) Status
Oropharynx	C09.0-1,8-9; C10.0,2-4,8-9	8000-8576, 8940-8950, 8980-8981	HPV (Human Papilloma Virus) Status
Nasopharynx	C11.0-3,8-9	8000-8576, 8940-8950, 8980-8981	HPV (Human Papilloma Virus) Status
Pharyngeal Tonsil	C11.1	8000-8576, 8940-8950, 8980-8981	HPV (Human Papilloma Virus) Status
Hypopharynx	C12.9; C13.0-2,8-9	8000-8576, 8940-8950, 8980-8981	HPV (Human Papilloma Virus) Status
PharynxOther	C14.0-2,8	8000-8576, 8940-8950, 8980-8981	HPV (Human Papilloma Virus) Status
SkinEyelid	C44.1	8000-8576, 8940-8950, 8980-8981	Prior Radiation
GISTPeritoneum	C48.0-2,8	8935-8936	Location of Primary Tumor
Breast	C50.0-6, 8-9	8000-8576, 8940-8950, 8980-8981, 9020	HER2: FISH Test Lab Value
Vulva	C51.0-2,8-9	8000-8246, 8248-8576,8940-8950, 8980-8981	FIGO Stage
Penis	C60.0-2,8-9	8000-8246, 8248-8576,8940-8950, 8980-8981,9020	Involvement of Corpus Spongiosum/Corpus Cavernosum
Prostate	C61.9	8000-8110, 8140-8576, 8940-8950, 8980-8981	Gleason's Score on Prostatectomy/Autopsy
MelanomaChoroid	C69.3	8720-8790	Mean Diameter Nucleoli (MLN)
MelanomaIris	C69.4	8720-8790	Mean Diameter Nucleoli (MLN)
MelanomaCiliary Body	C69.4	8720-8790	Mean Diameter Nucleoli (MLN)

Field 99e) CS SITE-SPECIFIC FACTOR 11

Item Length: 3
 Allowable Values: 000-999
 NAACCR Item #2865
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 11 (SSF11) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF11s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 11
Head and Neck*	See note after this table	8000–8576, 8940–8950, 8980–8981	Measured Thickness (Depth)
Mucosal Melanoma**	See note after this table	8720-8790	Measured Thickness (Depth)
NETStomach	C16.0-6,8-9	8153, 8240-8242, 8246, 8249	Serum Chromogranin A (CgA) Lab Value
GISTColon	C18.0,2-9	8935-8936	Mitotic Count
Appendix	C18.1	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Histopathologic Grading
GISTAppendix	C18.1	8935-8936	Mitotic Count
NETSmall Intestine	C17.0-3, 8-9	8153, 8240-8242, 8246, 8249	Serum Chromogranin A (CgA) Lab Value
GISTRectum	C19.9; C20.9	8935-8936	Mitotic Count
BileDucts Intrahepat	C22.0-1	8160-8161, 8180	Primary Sclerosing Cholangitis
BileDucts Perihilar	C24.0	8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981	Primary Sclerosing Cholangitis
Skin	C44.0,2-9	8000-8246, 8248-8576, 8940-8950, 8980-8981	Perineural Invasion
Breast	C50.0-6, 8-9	8000-8576, 8940-8950, 8980-8981, 9020	HER2: FISH Test Interpretation
Vulva	C51.0-2,8-9	8000-8246, 8248-8576, 8940-8950, 8980-8981	Regional Lymph Node - Laterality
MerkelCellVulva	C51.0-2,8-9	8247	Regional Lymph Node - Laterality
Prostate	C61.9	8000-8110, 8140-8576, 8940-8950, 8980-8981	Gleason Tertiary Pattern Value on Prostatectomy/Autopsy

Testis	C62.0-1,9	8000-8576, 8590-8670, 8940-8950, 8980-8981, 9060-9090, 9100-9105	Persistence of Elevated Serum Tumor Markers
Melanoma Choroid	C69.3	8720-8790	Extravascular Matrix Patterns, Loops
MelanomaIris	C69.4	8720-8790	Extravascular Matrix Patterns, Loops
MelanomaCiliary Body	C69.4	8720-8790	Extravascular Matrix Patterns, Loops

* Head and Neck: C00.0-6, 8, 9; C02.0-3, 8, 9; C03.0-1, 9; C05.8, 9; C06.8, 9; C30.0; C31.0-3, 8-9

** Mucosal Melanoma: C00.0-6,8-9; C01.9; C02.0-4,8-9; C03.0-1,9; C04.0-1,8-9; C05.0-2,8-9; C06.0-2,8-9; C09.0-1,8-9; C10.0-4,8-9; C11.0-3,8-9; C12.9; C13.2,8-9; C14.0,2,8; C30.0,2,8-9; C31.0-3,8-9; C32.0-3,8-9

Field 99f) CS SITE-SPECIFIC FACTOR 12

Item Length: 3
 Allowable Values: 000-999
 NAACCR Item #2866
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 12 (SSF12) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF12s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 12
NETStomach	C16.0-6,8-9	8153, 8240-8242, 8246, 8249	Urinary 5-HIAA Lab Value Level
NETSmall Intestine	C17.0-3, 8-9	8153, 8240-8242, 8246, 8249	Urinary 5-HIAA Lab Value Level
GISTColon	C18.0,2-9	8935-8936	KIT Immunohistochemistry (IHC)
GISTAppendix	C18.1	8935-8936	KIT Immunohistochemistry (IHC)
GISTRectum	C19.9; C20.9	8935-8936	KIT Immunohistochemistry (IHC)
Skin	C44.0,2-9	8000-8246, 8248-8576, 8940-8950, 8980-8981	High Risk Features
Breast	C50.0-6, 8-9	8000-8576, 8940-8950, 8980-8981, 9020	HER2: CISH Test Lab Value
Prostate	C61.9	8000-8110, 8140-8576, 8940-8950, 8980-8981	Number of Cores Positive
Scrotum	C63.2	8000-8246, 8248-8576, 8940-8950, 8980-8981	High Risk Features
Melanoma Choroid	C69.3	8720-8790	Extravascular Matrix Patterns, Networks
MelanomaIris	C69.4	8720-8790	Extravascular Matrix Patterns, Networks
MelanomaCiliary Body	C69.4	8720-8790	Extravascular Matrix Patterns, Networks

Field 99g) CS SITE-SPECIFIC FACTOR 13

Item Length: 3
 Allowable Values: 000-999
 NAACCR Item #2867
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 13 (SSF13) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF13s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 13
Breast	C50.0-6, 8-9	8000-8576, 8940-8950, 8980-8981, 9020	HER2: CISH Test Interpretation
Prostate	C61.9	8000-8110, 8140-8576, 8940-8950, 8980-8981	Number of Cores Examined
Melanoma Choroid	C69.3	8720-8790	Microvascular density (MVD)
MelanomaIris	C69.4	8720-8790	Microvascular density (MVD)
MelanomaCiliary Body	C69.4	8720-8790	Microvascular density (MVD)

Field 99h) CS SITE-SPECIFIC FACTOR 14

Item Length: 3
 Allowable Values: 000-999
 NAACCR Item #2868
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 14 (SSF14) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF14s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 14
Breast	C50.0-6, 8-9	8000-8576, 8940-8950, 8980-8981, 9020	HER2: Result of Other or Unknown Test

Field 99i) CS SITE-SPECIFIC FACTOR 15

Item Length: 3

Allowable Values: 000-999

NAACCR Item #2869

Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 15 (SSF15) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF15s used by the facility.

Field 99j) CS SITE-SPECIFIC FACTOR 16

Item Length: 3
 Allowable Values: 000-999
 NAACCR Item #2870
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 16 (SSF16) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF16s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 16
NETColon	C18.0,2-9	8153, 8240-8242, 8246, 8249	Serum Chromogranin A (CgA) Lab Value
NETRectum	C19.9, C20.9	8153, 8240-8242, 8246, 8249	Serum Chromogranin A (CgA) Lab Value
Skin	C44.0,2-9	8000-8246, 8248-8576, 8940-8950, 8980-8981	Size of Lymph Nodes
MerkelCellSkin	C44.0,2-9	8247	Size of Metastases in Lymph Nodes
MerkelCellVulva	C51.0-2,8-9	8247	Size of Metastases in Lymph Nodes
MerkelCellPenis	C60.0-2,8-9	8247	Size of Metastases in Lymph Nodes
MerkelCellScrotum	C63.2	8247	Size of Metastases in Lymph Nodes
Scrotum	C63.2	8000-8246, 8248-8576, 8940-8950, 8980-8981	Size of Lymph Nodes

Field 99k) CS SITE-SPECIFIC FACTOR 17

Item Length: 3
 Allowable Values: 000-999
 NAACCR Item #2871
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 17 (SSF17) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF17s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 17
NETColon	C18.0,2-9	8153, 8240-8242, 8246, 8249	Urinary 5-HIAA Lab Value Level
NETRectum	C19.9, C20.9	8153, 8240-8242, 8246, 8249	Urinary 5-HIAA Lab Value Level
MerkelCellSkin	C44.0,2-9	8247	Extracapsular Extension of Regional Lymph Nodes
MerkelCellVulva	C51.0-2,8-9	8247	Extracapsular Extension of Regional Lymph Nodes
MerkelCellPenis	C60.0-2,8-9	8247	Extracapsular Extension of Regional Lymph Nodes
MerkelCellScrotum	C63.2	8247	Extracapsular Extension of Regional Lymph Nodes
Penis	C60.0-2,8-9	8000-8246, 8248-8576, 8940-8950, 8980-8981, 9020	Extranodal Extension of Regional Lymph Nodes

Field 991) CS SITE-SPECIFIC FACTOR 18

Item Length: 3
 Allowable Values: 000-999
 NAACCR Item #2872
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 18 (SSF18) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF18s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 18
MerkelCellSkin	C44.0,2-9	8247	Isolated Tumor Cells (ITCs) in Regional Lymph Nodes(s)
MerkelCellVulva	C51.0-2,8-9	8247	Isolated Tumor Cells (ITCs) in Regional Lymph Nodes(s)
MerkelCellPenis	C60.0-2,8-9	8247	Isolated Tumor Cells (ITCs) in Regional Lymph Nodes(s)
MerkelCellScrotum	C63.2	8247	Isolated Tumor Cells (ITCs) in Regional Lymph Nodes(s)

Field 99m) CS SITE-SPECIFIC FACTOR 19

Item Length: 3

Allowable Values: 000-999

NAACCR Item #2873

Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 19 (SSF19) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF19s used by the facility.

Field 99n) CS SITE-SPECIFIC FACTOR 20

Item Length: 3

Allowable Values: 000-999

NAACCR Item #2874

Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 20 (SSF20) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF20s used by the facility.

Field 99o) CS SITE-SPECIFIC FACTOR 21

Item Length: 3
 Allowable Values: 000-999
 NAACCR Item #2875
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 21 (SSF21) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF21s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 21
Breast	C50.0-6, 8-9	8000-8576, 8940-8950, 8980-8981, 9020	Response to Neoadjuvant Therapy

Field 99p) CS SITE-SPECIFIC FACTOR 22

Item Length: 3
 Allowable Values: 000-999
 NAACCR Item #2876
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 22 (SSF22) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF22s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 22
MerkelCellSkin	C44.0,2-9	8247	Profound Immune Suppression
MerkelCellVulva	C51.0-2,8-9	8247	Profound Immune Suppression
MerkelCellPenis	C60.0-2,8-9	8247	Profound Immune Suppression
MerkelCellScrotum	C63.2	8247	Profound Immune Suppression
Breast	C50.0-6, 8-9	8000-8576, 8940-8950, 8980-8981, 9020	Multigene Signature Method

Field 99q) CS SITE-SPECIFIC FACTOR 23

Item Length: 3
 Allowable Values: 000-999
 NAACCR Item #2877
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 23 (SSF23) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF23s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 23
Breast	C50.0-6, 8-9	8000-8576, 8940-8950, 8980-8981, 9020	Result/Score of the Multigene Signature

Field 99r) CS SITE-SPECIFIC FACTOR 24

Item Length: 3

Allowable Values: 000-999

NAACCR Item #2878

Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other materials from another source, it may be used.

For tumors abstracted in CSv2 or diagnosed in 2010, the following Site –Specific Factor 24 (SSF24) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF24s used by the facility.

Field 99s) CS SITE-SPECIFIC FACTOR 25

Item Length: 3

Allowable Values: 000-999

NAACCR Item #2879

Source of Information: *FORDS: Revised for 2010*

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

CS Site-Specific Factor 25 is used to discriminate between CS staging schema or between AJCC chapters where site and histology alone are insufficient to identify the tumor type or location to identify the applicable staging method. Use of this item is limited to specific subsites and histologies as shown below.

Instructions for Coding

- Refer to the site and histology-specific instructions in the *Collaborative Staging Manual* for coding instructions.

The following Site –Specific Factor 25 (SSF25) items are *required* by CoC to be coded.

CS Schema	Sites	Histologies	Site-Specific Factor 25
Nasopharynx	C11.1	8000-8576, 8940-8950, 8980-8981	Schema Discriminator
Pharyngeal Tonsil	C11.1	8000-8576, 8940-8950, 8980-8981	Schema Discriminator
EsophagusGE Junction	C16.1-2	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981	Involvement of Cardia and Distance from Esophagogastric Junction (EGJ)
Stomach	C16.1-2	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8990	Involvement of Cardia and Distance from Esophagogastric Junction (EGJ)
Cystic Duct	C24.0	8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981	Schema Discriminator: Subsite of Extrahepatic Bile Ducts
BileDuctsPerihilar	C24.0	8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981	Schema Discriminator: Subsite of Extrahepatic Bile Ducts
BileDuctsDistal	C24.0	8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981	Schema Discriminator: Subsite of Extrahepatic Bile Ducts
Peritoneum	C48.1-2,8	8000-8576, 8590-8671, 8930-8934, 8940-9110	Schema Discriminator
PeritoneumFemaleGen	C48.1-2,8	8000-8576, 8590-8671, 8930-8934, 8940-9110	Schema Discriminator
MelanomaCiliaryBody	C69.4	8720-8790	Schema Discriminator: Melanoma Ciliary Body/Melanoma Iris
MelanomaIris	C69.4	8720-8790	Schema Discriminator: Melanoma Ciliary Body/Melanoma Iris
Lacrimal Gland	C69.5	8000-8576, 8940-8950, 8980-8981	Schema Discriminator: Lacrimal Gland/Lacrimal Sac
Lacrimal Sac	C69.5	8000-8576, 8940-8950, 8980-8981	Schema Discriminator: Lacrimal Gland/Lacrimal Sac

Field 100) SUMMARY STAGE

Item Length: 1
 Allowable Values: 0-5, 7, 9
 NAACCR Item #759
 Source of Information: *OCISS*

Description

Provides a site-specific description of the extent of disease at diagnosis.

Rationale

SEER Summary Stage 2000 is used by the CoC to describe disease spread at diagnosis for cancers with no AJCC TNM staging schema. It is a prognostic factor used in the analysis of patient care and outcomes.

Instructions for Coding

- Code this data item for cases diagnosed on or after January 1, 2001 and prior to January 1, 2004.
- Refer to the *SEER Summary Staging Manual 2000* for site-specific coding instructions. This information can be found online at <http://www.seer.cancer.gov/Publications/SummaryStage/>

Code	Definition
0	In situ.
1	Localized.
2	Regional by direct extension.
3	Regional to lymph nodes.
4	Regional (both codes 2 and 3).
5	Regional, NOS
7	Distant metastasis/systemic disease.
9	Unknown if extension or metastasis (unstaged, unknown, or unspecified); death certificate only.

Field 101) SUMMARY STAGE SUBSTANTIATING TEXT

Item Length: 1000

Allowable Values: Letters and Numbers

NAACCR Item #2600

Source of Information: *NAACCR Data Dictionary, Version 12*

Description

Additional text area for staging information not already entered in other Text fields.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should NOT be generated electronically from coded values.

Instructions for Coding

- Code this data item for cases diagnosed on or after January 1, 2001 and prior to January 1, 2004.
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See Appendix 8 in this manual).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date(s) of procedure(s), including clinical procedures, that provided information for assigning stage
- Organs involved by direct extension
- Size of tumor
- Status of margins
- Number and sites of positive lymph nodes
- Site(s) of distant metastasis
- Physician's specialty and comments

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

OCISS Field Number	OCISS Field Name	NAACCR Item Number
Field 41b	RX Date – DX/Stg Proc	1280
Fields 85 - 99	Collaborative Stage Variables	2800 - 2930
Field 100	SEER Summary Stage 1977	760
Field 100	Summary Stage 2000	759
Field 90 or Field 104	CS Number of Regional Lymph Nodes Positive or Number of Regional Nodes Positive	820 820
Field 91 or Field 103	CS Number of Regional Lymph Nodes Examined or Number of Regional Nodes Examined	830 830
Not collected by OCISS Field 49	RX Hosp – Surg Prim Site Surgery Code	670 1290
Not collected by OCISS Field 72	RX Hosp – Scope Reg LN Sur RX Summ – Scope Reg LN Sur	672 1292
Not collected by OCISS Field 73	RX Hosp – Surg Oth Reg/Dis RX Summ – Surg Oth Reg/Dis	674 1294
Not collected by OCISS Field 29	Mult Tum Rpt as One Prim Laterality at Diagnosis	444 410

Field 102) SIZE OF TUMOR (in mm)	Item Length: 3 Allowable Values: 000-995, 999 NAACCR Item #780 Source of Information: <i>NAACCR Data Dictionary, Version 12</i>
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Description

Part of the 10-digit EOD [779]. Detailed site-specific codes for anatomic EOD used by SEER for tumors diagnosed from 1988 forward.

This field is included in the CoC dataset, separate from EOD.

Codes were revised effective January 1, 1998, to reflect changes in the *AJCC Cancer Staging Manual*, Fifth Edition.

Rationale

Site-specific EOD codes provide extensive detail describing disease extent. The EOD codes can be grouped into different stage categories for analysis (e.g., historical summary stage categories consistent with those used in published SEER data since 1973, or more recently, AJCC stage groupings). The codes are updated as needed, but updates are usually backward compatible with old categories. See *Comparative Staging Guide for Cancer*.

Instructions for Coding

- See *SEER Extent of Disease, 1988; Codes and Coding Instructions*, Third Edition, for site-specific codes and coding rules for all EOD fields. The CoC codes for Tumor Size are in the *FORDS* manual.

Note: See Chapter V, Unresolved Issues, for a discussion of coding differences between CoC and SEER.

Field 103) NUMBER OF REGIONAL NODES EXAMINED

Item Length: 2

Allowable Values: 00-90, 95-99

NAACCR Item #830

Source of Information: *FORDS: Revised for 2010*

Description

Records the total number of regional lymph nodes that were removed and examined by the pathologist. Beginning with cases diagnosed on or after January 1, 2004, this item became a component of the Collaborative Staging System (CS).

Rationale

This data item serves as a quality measure of the pathologic and surgical evaluation and treatment of the patient.

Instructions for Coding

- Refer to the site/histology-specific instructions in the current *Collaborative Staging Manual* for codes and Instructions for Coding.

Field 104) NUMBER OF REGIONAL LYMPH NODES POSITIVE

Item Length: 2

Allowable Values: 00-99

NAACCR Item #820

Source of Information: *FORDS: Revised for 2010*

Description

Records the exact number of regional lymph nodes examined by the pathologist and found to contain metastases. Beginning with cases diagnosed on or after January 1, 2004, this item became a component of the Collaborative Staging System (CS).

Rationale

This data item is necessary for pathologic staging, and it serves as a quality measure for pathology reports and the extent of the surgical evaluation and treatment of the patient.

Instructions for Coding

- Refer to the site/histology-specific instructions in the current *Collaborative Staging Manual* for codes and Instructions for Coding.

Field 105) TUMOR (Clinical T - AJCC) Item Length: 4
 Allowable Values: Uppercase Alphanumeric
 NAACCR Item #940
 Source of Information: *FORDS: Revised for 2010*

Description
 Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known *prior* to the start of any therapy.

Rationale
 The Commission on Cancer (CoC) requires that AJCC TNM staging be used in its approved cancer programs. Effective January 1, 2008, the CoC requires that AJCC clinical TNM staging be recorded in its accredited cancer program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- The clinical T staging element must be recorded for *Class of Case 10-22*.
- It is strongly recommended that the clinical T staging element be recorded for *Class of Case 00* cases if the patient’s workup at the facility allows coding of clinical T.
- Code clinical T as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded clinical T, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- For lung, occult carcinoma is coded TX.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition	Code	Definition	Code	Definition
(leave 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, T1mic	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

Field 106) NODE (Clinical N - AJCC) Item Length: 4
 Allowable Values: Uppercase Alphanumeric
 NAACCR Item #950
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known *prior* to the start of any therapy.

Rationale

The Commission on Cancer (CoC) requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2008, the CoC requires that AJCC clinical TNM staging be recorded in its approved cancer program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- The clinical N staging element must be recorded for *Class of Case* 10-22.
- It is strongly recommended that the clinical N staging element be recorded for *Class of Case* 00 cases if the patient’s workup at the facility allows coding of clinical N.
- Record clinical N 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 *will* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition	Code	Definition
(leave 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	3B	N3b
0B	N0b	3C	N3c
1	N1	4	N4
1A	N1a	88	Not applicable

Field 107) METASTASIS (Clinical M - AJCC)

Item Length: 4
 Allowable Values: Uppercase Alphanumeric
 NAACCR Item #960
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies the presence or absence of distant metastasis (M) of the tumor known *prior* to the start of any therapy.

Rationale

The Commission on Cancer (CoC) requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2008, the CoC requires that AJCC clinical TNM staging be recorded in its approved cancer program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- The clinical M staging element must be recorded for *Class of Case* 10-22.
- It is strongly recommended that the clinical M staging element be recorded for *Class of Case* 00 cases if the patient's workup at the facility allows coding of clinical M.
- Record clinical M as documented by the first treating physician or managing physician in the medical record.
- If the managing physician has not recorded clinical M, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition
(leave 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

Field 108) STAGE GROUP (Clinical - AJCC)

Item Length: 4

Allowable Values: Uppercase Alphanumeric

NAACCR Item #970

Source of Information: *FORDS: Revised for 2010*

Description

Identifies the anatomic extent of disease based on the T, N, and M elements known *prior* to the start of any therapy.

Rationale

The Commission on Cancer (CoC) requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2008, the CoC requires that AJCC clinical TNM staging be recorded in its approved cancer program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Record the clinical stage group as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded clinical stage, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- To assign stage group when some, but not all, T, N and/or M components can be determined, interpret missing components as “X”.
- If the value is only one digit, then record to the left and leave the second space blank.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition	Code	Definition	Code	Definition
0	Stage 0	1S	Stage IS	3C1	Stage IIIC1
0A	Stage 0A	2	Stage II	3C2	Stage IIIC2
0IS	Stage 0is	2A	Stage IIA	4	Stage IV
1	Stage I	2A1	Stage IIA1	4A	Stage IVA
1A	Stage IA	2A2	Stage IIA2	4A1	Stage IVA1
1A1	Stage IA1	2B	Stage IIB	4A2	Stage IVA2
1A2	Stage IA2	2C	Stage IIC	4B	Stage IVB
1B	Stage IB	3	Stage III	4C	Stage IVC
1B1	Stage IB1	3A	Stage IIIA	OC	Occult
1B2	Stage IB2	3B	Stage IIIB	88	Not applicable
1C	Stage IC	3C	Stage IIIC	99	Unknown

Field 109) STAGE GROUP TEXT (Clinical - AJCC)

Item Length: 1000

Allowable Values: Letters and Numbers

NAACCR Item #2600

Source of Information: *NAACCR Data Dictionary, Version 12*

Description

Additional text area for staging information not already entered in other Text fields.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should NOT be generated electronically from coded values.

Instructions for Coding

- Code this data item for cases diagnosed on or after January 1, 2001 and prior to January 1, 2004.
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See Appendix 8 in this manual).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date(s) of procedure(s), including clinical procedures, that provided information for assigning stage
- Organs involved by direct extension
- Size of tumor
- Status of margins
- Number and sites of positive lymph nodes
- Site(s) of distant metastasis
- Physician's specialty and comments

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

OCISS Field Number	OCISS Field Name	NAACCR Item Number
Field 41b	RX Date – DX/Stg Proc	1280
Fields 85 - 99	Collaborative Stage Variables	2800 - 2930
Field 100	SEER Summary Stage 1977	760
Field 100	Summary Stage 2000	759
Field 90 or Field 104	CS Number of Regional Lymph Nodes Positive or Number of Regional Nodes Positive	820 820
Field 91 or Field 103	CS Number of Regional Lymph Nodes Examined or Number of Regional Nodes Examined	830 830
Not collected by OCISS Field 49	RX Hosp – Surg Prim Site Surgery Code	670 1290
Not collected by OCISS Field 72	RX Hosp—Scope Reg LN Sur RX Summ – Scope Reg LN Sur	672 1292
Not collected by OCISS Field 73	RX Hosp – Surg Oth Reg/Dis RX Summ – Surg Oth Reg/Dis	674 1294
Not collected by OCISS Field 29	Mult Tum Rpt as One Prim Laterality	444 410

Field 110) STAGE DESCRIPTOR (Clinical - AJCC)

Item Length: 1

Allowable Values: 0-3, 5, 9

NAACCR Item #980

Source of Information: *FORDS: Revised for 2010*

Description

Identifies the AJCC clinical stage (prefix/suffix) descriptor of the tumor *prior* to the start of any therapy. Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the stage group.

Rationale

The Commission on Cancer (CoC) requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2008, the CoC requires that AJCC clinical TNM staging be recorded in its approved cancer program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Record the clinical stage (prefix/suffix) descriptor as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded the descriptor, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- Previous editions of FORDS included a code 4 for y-classification, and a note that it was not applicable for clinical stage. Code 4 has been removed from the list of valid codes.

Code	Label	Description
0	None	There are no prefix or suffix descriptors that would be used for this case.
1	E--Extranodal, lymphomas only	A lymphoma case involving an extranodal site.
2	S--Spleen, lymphomas only	A lymphoma case involving the spleen.
3	M--Multiple primary tumors in a single site	This is one primary with multiple tumors in the primary site at the time of diagnosis.
5	E&S--Extranodal and spleen, lymphomas only	A lymphoma case with involvement of both an extranodal site and the spleen.
9	Unknown; not stated in patient record	A prefix or suffix would describe this stage, but it is not known which would be correct.

Field 111) STAGE RECORDED BY (Staged By) (Clinical - AJCC)

Item Length: 1

Allowable Values: 0-9

NAACCR Item #990

Source of Information: *FORDS: Revised for 2010*

Description

Identifies the person who recorded the clinical AJCC staging elements and the stage group.

Rationale

Effective January 1, 2008, the CoC requires that AJCC clinical TNM staging be recorded in its accredited cancer program cancer registries. Data captured in this field can be used to evaluate the accuracy and completeness of staging recorded in the registry and form the basis for quality management and improvement studies.

Instructions for Coding

- Record the person who documented the clinical AJCC staging elements and the stage group.
- If code 1, 2, or 5 is used, then all of the staging elements (T, N, and M) and stage group must be recorded by the same person.
- The staging elements (T, N, M) and the stage group must be recorded.

Code	Label	Definition
0	Not staged	Clinical staging was not assigned.
1	Managing physician	Clinical staging was assigned by the managing physician.
2	Pathologist	Clinical staging was assigned by the pathologist only.
3	Pathologist and managing physician	Clinical staging was assigned by the pathologist and the managing physician.
4	Cancer Committee chair, cancer liaison physician, or registry physician advisor	Clinical staging was assigned by the Cancer Committee chair, cancer liaison physician, or the registry physician advisor during a quality control review.
5	Cancer registrar	Clinical staging was assigned by the cancer registrar only.
6	Cancer registrar and physician	Clinical staging was assigned by the cancer registrar and any of the physicians specified in codes 1-4.
7	Staging assigned at another facility	Clinical staging was assigned by a physician at another facility.
8	Case is not eligible for staging	An AJCC staging scheme has not been developed for this site. The histology is excluded from an AJCC site scheme.
9	Unknown; not stated in patient record	It is unknown whether or not the case was staged.

Field 112) TUMOR (Pathologic T - AJCC)

Item Length: 4
 Allowable Values: Uppercase Alphanumeric
 NAACCR Item #880
 Source of Information: *FORDS: Revised for 2010*

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known *following* the completion of surgical therapy.

Rationale

The Commission on Cancer (CoC) requires that AJCC TNM staging be used in its accredited cancer programs. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Code 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 with the physician.
- Truncate the least significant subdivision of the category from the right as needed.
- For lung, occult carcinoma is coded TX.
- The CoC recommends that pathologic T be recorded for *Class of Case* 10-22 cases diagnosed on or after January 1, 2008.

Code	Definition	Code	Definition	Code	Definition
(leave 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
IMI	T1mi, T1mic	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

Field 113) NODE (Pathologic N - AJCC)

Item Length: 4
 Allowable Values: Uppercase Alphanumeric
 NAACCR Item #890
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known *following* the completion of surgical therapy.

Rationale

The Commission on Cancer (CoC) requires that AJCC TNM staging be used in its accredited cancer programs. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Code pathologic N as documented by the treating physician(s) or the 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.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The CoC recommends that pathologic N be recorded for *Class of Case* 10-22 cases diagnosed on or after January 1, 2008.

Code	Definition	Code	Definition
(leave 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	3B	N3b
0B	N0b	3C	N3c
1	N1	4	N4
1A	N1a	88	Not applicable

Field 114) METASTASIS (Pathologic M - AJCC)

Item Length: 4

Allowable Values: Uppercase Alphanumeric

NAACCR Item #900

Source of Information: *FORDS: Revised for 2010*

Description

Identifies the presence or absence of distant metastasis (M) of the tumor known *following* the completion of surgical therapy.

Rationale

The Commission on Cancer (CoC) requires that AJCC TNM staging be used in its accredited cancer programs. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Code pathologic M as documented by the treating physician(s) or the 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 treating physician.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The CoC recommends that pathologic M be recorded for *Class of Case* 10-22 cases diagnosed on or after January 1, 2008.

Code	Definition
(leave 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

Field 115) STAGE GROUP (Pathologic - AJCC)

Item Length: 4
 Allowable Values: Uppercase Alphanumeric
 NAACCR Item #910
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies the anatomic extent of disease based on the T, N, and M elements known *following* the completion of surgical therapy.

Rationale

The Commission on Cancer (CoC) requires that AJCC TNM staging be used in its accredited cancer programs. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Record the pathologic stage group as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded the pathologic stage, registrars *should* code this item based on the best available information, without necessarily requiring additional contact with the physician(s).
- To assign stage group when some, but not all, of the T, N, and/or M components can be determined, interpret missing components as “X.”
- If pathologic M,(NAACCR Item #900) is coded as either X or blank and clinical M (NAACCR Item #960) is coded as 0, 1, 1A, 1B, or 1C, then the combination of staging elements pT, pN, and, cM, (NAACCR Items #880, 890, 960) may be used to complete the pathologic stage group.
- If the value is only one digit, record to the left and leave the second space blank.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The CoC recommends that pathologic stage group be recorded for *Class of Case 10-22* cases diagnosed on or after January 1, 2008.

Code	Definition	Code	Definition	Code	Definition
0	Stage 0	1S	Stage IS	3C1	Stage IIIC1
0A	Stage 0A	2	Stage II	3C2	Stage IIIC2
0IS	Stage 0is	2A	Stage IIA	4	Stage IV
1	Stage I	2A1	Stage IIA1	4A	Stage IVA
1A	Stage IA	2A2	Stage IIA2	4A1	Stage IVA1
1A1	Stage IA1	2B	Stage IIB	4A2	Stage IVA2
1A2	Stage IA2	2C	Stage IIC	4B	Stage IVB
1B	Stage IB	3	Stage III	4C	Stage IVC
1B1	Stage IB1	3A	Stage IIIA	OC	Occult
1B2	Stage IB2	3B	Stage IIIB	88	Not applicable
1C	Stage IC	3C	Stage IIIC	99	Unknown

Field 116) STAGE GROUP TEXT (Pathologic - AJCC)

Item Length: 1000

Allowable Values: Letters and Numbers

NAACCR Item #2600

Source of Information: *NAACCR Data Dictionary, Version 12*

Description

Additional text area for staging information not already entered in other Text fields.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should NOT be generated electronically from coded values.

Instructions for Coding

- Code this data item for cases diagnosed on or after January 1, 2001 and prior to January 1, 2004.
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized. (See Appendix 8.)
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date(s) of procedure(s), including clinical procedures, that provided information for assigning stage
- Organs involved by direct extension
- Size of tumor
- Status of margins
- Number and sites of positive lymph nodes
- Site(s) of distant metastasis
- Physician's specialty and comments

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

OCISS Field Number	OCISS Field Name	NAACCR Item Number
Field 41b	RX Date – DX/Stg Proc	1280
Fields 85 - 99	Collaborative Stage Variables	2800 - 2930
Field 100	SEER Summary Stage 1977	760
Field 100	SEER Summary Stage 2000	759
Field 90 or Field 104	CS Number of Regional Lymph Nodes Positive or Number of Regional Nodes Positive	820 820
Field 91 or Field 103	CS Number of Regional Lymph Nodes Examined or Number of Regional Nodes Examined	830 830
Not collected by OCISS Field 49	RX Hosp – Surg Prim Site Surgery Code	670 1290
Not collected by OCISS Field 72	RX Hosp – Scope Reg LN Sur RX Summ – Scope Reg LN Sur	672 1292
Not collected by OCISS Field 73	RX Hosp – Surg Oth Reg/Dis RX Summ – Surg Oth Reg/Dis	674 1294
Not collected by OCISS Field 29	Mult Tum Rpt as One Prim Laterality	444 410

Field 117) STAGE DESCRIPTOR (Pathologic - AJCC)

Item Length: 1

Allowable Values: 0-6, 9

NAACCR Item #920

Source of Information: *FORDS: Revised for 2010*

Description

Identifies the AJCC pathologic stage (prefix/suffix) descriptor known *following* the completion of surgical therapy.

Rationale

Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the stage group. The Commission on Cancer (CoC) requires that AJCC TNM staging be used in its accredited cancer programs. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Record the pathologic stage group (prefix/suffix) descriptor as documented by the treating physician(s) or managing physician in the medical record.
- If the managing physician has not recorded the descriptor, registrars *should* code this item based on the best available information, without necessarily requiring additional contact with the physician(s).
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition	Code
0	None	There are no prefix or suffix descriptors that would be used for this case.
1	E--Extranodal, lymphomas only	A lymphoma case involving an extranodal site.
2	S--Spleen, lymphomas only	A lymphoma case involving the spleen.
3	M--Multiple primary tumors in a single site	This is one primary with multiple tumors in the organ of origin at the time of diagnosis.
4	Y--Classification during or after initial multimodality therapy, pathologic staging only	Not applicable for clinical stage.
5	E&S--Extranodal and spleen, lymphomas only	A lymphoma case with involvement of both an extranodal site and the spleen.
6	M&Y--Multiple primary tumors and initial multimodality therapy	A case meeting the parameters of both codes 3 (multiple primary tumors in a single site) and 4 (classification during or after initial multimodality therapy).
9	Unknown; not stated in patient record	A prefix or suffix would describe this stage, but it is not known which would be correct.

Field 118) STAGE RECORDED BY (Staged By) (Pathologic - AJCC)

Item Length: 1

Allowable Values: 0-9

NAACCR Item #930

Source of Information: *FORDS: Revised for 2010*

Description

Identifies the person who recorded the pathologic AJCC staging elements and the stage group.

Rationale

Data captured in this field can be used to evaluate the accuracy and completeness of staging and form the basis for quality management and improvement studies.

Instructions for Coding

- Record the person who documented the pathologic AJCC staging elements and the stage group.
- If code 1, 2, or 5 is used, then all of the staging elements (T, N, and M) and stage group must be recorded by the same person.
- The staging elements (T, N, M) and the stage group must be recorded.

Code	Label	Definition
0	Not staged	Pathologic staging was not assigned.
1	Managing physician	Pathologic staging was assigned by the managing physician.
2	Pathologist	Pathologic staging was assigned by the pathologist only.
3	Pathologist and managing physician	Pathologic staging was assigned by the pathologist and the managing physician.
4	Cancer Committee chair, cancer liaison physician, or registry physician advisor	Pathologic staging was assigned by the Cancer Committee chair, cancer liaison physician, or the registry physician advisor during a quality control review.
5	Cancer registrar	Pathologic staging was assigned by the cancer registrar only.
6	Cancer registrar and physician	Pathologic staging was assigned by the cancer registrar and any of the physicians specified in codes 1-4.
7	Staging assigned at another facility	Pathologic staging was assigned by a physician at another facility.
8	Case is not eligible for staging	An AJCC staging scheme has not been developed for this site. The histology is excluded from an AJCC site scheme.
9	Unknown; not stated in patient record	It is unknown whether or not the case was staged.

Field 119) SOURCE TYPE (Type of Reporting Source)

Item Length: 1

Allowable Values: 1-8

NAACCR Item #500

Source of Information: *NAACCR Data Dictionary, Version 12*

Description

This variable codes the source documents used to abstract the majority of information on the tumor being reported. This may not be the source of original case finding (for example, if a case is identified through a pathology laboratory report review and all source documents used to abstract the case are from the physician’s office, code this item 4).

Rationale

The code in this field can be used to explain why information may be incomplete on a tumor. For example, death certificate only cases have unknown values for many data items, so one may want to exclude them from some analyses. The field also is used to monitor the success of non-hospital case reporting and follow-back mechanisms. All population-based registries should have some death certificate-only cases where no hospital admission was involved, but too high a percentage can imply both shortcomings in case-finding and that follow-back to uncover missed hospital reports was not complete.

Instructions for Coding

- Code in the following priority order: 1, 2, 8, 4, 3, 5, 6, 7. This is a change to reflect the addition of codes 2 and 8 and to prioritize laboratory reports 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.
- This data item is intended to indicate the completeness of information available to the abstractor. Reports from health plans (e.g., Kaiser, Veterans Administration, military facilities) in which all diagnostic and treatment information is maintained centrally and is available to the abstractor are expected to be at least as complete as reports for hospital inpatients, which is why these sources are grouped with inpatients and given the code with the highest priority.
- Sources coded with ‘2’ usually have complete information on the cancer diagnosis, staging, and treatment.
- Sources coded with ‘8’ would include, but would not be limited to, outpatient surgery and nuclear medicine services. A physician’s office that calls itself a surgery center should be coded as a physician’s office. Surgery centers are equipped to perform surgical procedures under general anesthesia. If a physician’s office calls itself a surgery center, but cannot perform surgical procedures under general anesthesia, code as a physician office.

Code	Definition
1	Hospital inpatient; Managed health plans with comprehensive, unified medical records
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)
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

Field 120) PRIMARY PAYER AT DIAGNOSIS

Item Length: 2
 Allowable Values: 01, 02, 10, 20, 21, 31, 35, 60-68, 99
 NAACCR Item #630
 Source of Information: *FORDS: Revised for 2010*

Description

Identifies the patient’s primary payer/insurance carrier at the time of initial diagnosis and/or treatment.

Rationale

This item is used in financial analysis and as an indicator for quality and outcome analyses. The Joint Commission requires the patient admission page to document the type of insurance or payment structure that will cover the patient while being cared for at the hospital.

Instructions for Coding

- If the patient is diagnosed at the reporting facility, record the payer at the time of diagnosis.
- If the patient is diagnosed elsewhere or the payer at the time of diagnosis is not known record the payer when the patient is initially admitted for treatment.
- Record the type of insurance reported on the patient’s admission page.
- Codes 21 and 65-68 are to be used for patients diagnosed on or after January 1, 2006.
- If more than one payer or insurance carrier is listed on the patient’s admission page record the first.
- If the patient’s payer or insurance carrier changes, do not change the initially recorded code.

Code	Label	Definition
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, 21, 31, 35, 60-68.
20	Private Insurance: Managed Care, HMO, or PPO	An organized system of prepaid care for a group of enrollees usually within a defined geographic area. Generally formed as one of four types: a group model, an independent physician association (IPA), a network, or a staff model. “Gate-keeper model” is another term for describing this type of insurance.
21	Private Insurance: Fee-for-Service	An insurance plan that does not have a negotiated fee structure with the participating hospital. Type of insurance plan not coded as 20.
31	Medicaid	State government administered insurance for persons who are uninsured, below the poverty level, or covered under entitlement programs. Medicaid other than described in code 35.
35	Medicaid administered through a Managed Care plan	Patient is enrolled in Medicaid through a Managed Care program (e.g. HMO or PPO). The Managed Care plan pays for all incurred costs.
60	Medicare without supplement, Medicare, NOS	Federal government funded insurance for persons who are 62 years of age or older, or are chronically disabled (Social Security insurance eligible). Not described in codes 61, 62, or 63.
61	Medicare with supplement, NOS	Patient had Medicare and another type of unspecified insurance to pay costs not covered by Medicare.
62	Medicare administered through a Managed Care plan	Patient is enrolled in Medicare through a Managed Care plan (e.g. HMO or PPO). The Managed Care 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.

Code	Label	Definition
65	TRICARE	Department of Defense program providing supplementary civilian-sector hospital and medical services beyond a military treatment facility to military dependents, retirees, and other dependents. Formally CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).
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 or at another facility, and the medical costs are reimbursed by the Indian Health Service. Patient who receives care at a Public Health Service facility or at another facility, and the medical costs are reimbursed by the Public Health Service.
99	Insurance status unknown	It is unknown from the patient's medical record whether or not the patient is insured.

Example

Code	Reason
01	An indigent patient is admitted with no insurance coverage.
20	A patient is admitted for treatment and the patient admission page states the primary insurance carrier is an HMO.
62	A 65-year old male patient is admitted for treatment and the patient admission page states the patient is covered by Medicare with additional insurance coverage from a PPO.

Field 121) INITIALS OF PERSON WHO ABSTRACTED THIS CASE (Abstracted By)

Item Length: 3

Allowable Values: Letters

NAACCR Item #570

Source of Information: *FORDS: Revised for 2010*

Description

Records the initials or assigned code of the individual abstracting the case.

Rationale

This item can be used for quality control and management in multistaffed registries.

Instructions for Coding

Code the initials of the abstractor.

Code	Definition
(fill spaces)	Initials or code of abstractor.

APPENDIX 1

Ohio Revised Code, Sections 3701.261-3701.264
Ohio Revised Code, Section 3701.99
Ohio Administrative Code, Chapter 3701-4

LAWriter® Ohio Laws and Rules - <http://codes.ohio.gov/oac>
Baldwin's Ohio Revised Code Annotated, Thompson/West 2006 –
<http://www.lkwdpl.org/legalgov/ohio.htm>

Baldwin's Ohio Administrative Code, Approved Edition, Thompson/West
2006 -
<http://www.lkwdpl.org/legalgov/ohio.htm>

3701.261 Ohio cancer incidence surveillance system.

(A) The director of health shall:

(1) Establish a population-based cancer registry, which shall be known as the Ohio cancer incidence surveillance system, to monitor the incidence of various types of malignant diseases in Ohio, make appropriate epidemiologic studies to determine any causal relations of such diseases with occupational, nutritional, environmental, or infectious conditions, and alleviate or eliminate any such conditions;

(2) Advise, consult, cooperate with, and assist, by contract or otherwise, agencies of the state and federal government, agencies of the governments of other states, agencies of political subdivisions of this state, universities, private organizations, corporations, and associations for the purposes of division (A)(1) of this section;

(3) Accept and administer grants from the federal government or other sources, public or private, for carrying out any of the functions enumerated in divisions (A)(1) and (2) of this section.

(B) The Ohio cancer incidence surveillance system shall follow a model of cancer data collection as set forth by the survey epidemiology and end results system (SEERS).

Effective Date: 09-29-1997

3701.262 Cancer incidence surveillance system rules.

(A) As used in this section and section 3701.263 of the Revised Code:

(1) "Physician" means a person who holds a valid certificate issued under Chapter 4731. of the Revised Code authorizing the person to practice medicine or surgery or osteopathic medicine and surgery.

(2) "Dentist" means a person who is licensed under Chapter 4715. of the Revised Code to practice dentistry.

(3) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.

(4) "Cancer" includes those diseases specified by rule of the director of health under division (B)(2) of this section.

(B) The director of health shall adopt rules in accordance with Chapter 119. of the Revised Code to do all of the following:

(1) Establish the Ohio cancer incidence surveillance system required by section 3701.261 of the Revised Code;

(2) Specify the types of cancer and other tumorous and precancerous diseases to be reported to the department of health under division (D) of this section.

(3) Establish reporting requirements for information concerning diagnosed cancer cases as the director considers necessary to conduct epidemiologic surveys of cancer in this state;

(4) Establish standards that must be met by research projects to be eligible to receive information from the department of health under division (B) of section 3701.263 of the Revised Code.

(C) The department of health shall record in the registry all reports of cancer received by it. In the development and administration of the cancer registry the department may use information compiled by public or private cancer registries and may contract for the collection and analysis of, and research related to, the information recorded under this section.

(D) Each physician, dentist, hospital, or person providing diagnostic or treatment services to patients with cancer shall report each case of cancer to the department. Any person required to report pursuant to this section may elect to report to the department through an existing cancer registry if the registry meets the reporting standards established by the director and reports to the department.

(E) All physicians, dentists, hospitals, or persons providing diagnostic or treatment services to patients with cancer shall grant to the department or its authorized representative access to all records that identify cases of cancer or establish characteristics of cancer, the treatment of cancer, or the medical status of any identified cancer patient.

(F) The Arthur G. James and Richard J. Solove research institute of the Ohio state university, shall analyze and evaluate the cancer reports collected pursuant to this section. The department shall publish and make available to the public reports summarizing the information collected. Reports shall be made on a calendar year basis and published not later than ninety days after the end of each calendar year.

(G) Furnishing information, including records, reports, statements, notes, memoranda, or other information, to the department of health, either voluntarily or as required by this section, or to a person or governmental entity designated as a medical research project by the department, does not subject a physician, dentist, hospital, or person providing diagnostic or treatment services to patients with cancer to liability in an action for damages or other relief for furnishing the information.

(H) This section does not affect the authority of any person or facility providing diagnostic or treatment services to patients with cancer to maintain facility-based tumor registries, in addition to complying with the reporting requirements of this section.

(I) No person shall fail to make the cancer reports required by division (D) of this section.

Effective Date: 10-29-2003

3701.263 Confidentiality.

(A) Any information, data, and reports with respect to a case of malignant disease which are furnished to, or procured by, any cancer registry in this state or the department of health shall be confidential and shall be used only for statistical, scientific, and medical research for the purpose of reducing the morbidity or mortality of malignant disease. No physician, dentist, person, or hospital furnishing such information, data, or report to any such cancer registry or the department of health, with respect to a case of malignant disease treated or examined by such physician, dentist, or person, or confined in such hospital, shall by reason of such furnishing be deemed to have violated any confidential relationship, or be held liable in damages to any person, or be held to answer for willful betrayal of a professional confidence within the meaning and intent of section 4731.22 of the Revised Code.

(B) The department of health shall prescribe a release of confidential information form for use under this division.

Information concerning individual cancer patients obtained by the department of health for the Ohio cancer incidence surveillance system is for the confidential use of the department only, except as follows:

(1) The department shall grant to a person involved in a medical research project that meets the standards established by the director of health under section 3701.262 of the Revised Code access to confidential information concerning individual cancer patients if all of the following conditions are met:

(a) The person conducting the research provides written information about the purpose of the research project, the nature of the data to be collected and how the researcher intends to analyze it, the records the researcher seeks to review, and the safeguards the researcher will take to protect the identity of patients whose records the researcher will be reviewing.

(b) In the view of the director of health, the proposed safeguards are adequate to protect the identity of each patient whose records will be reviewed.

(c) An agreement is executed between the department and the researcher that specifies the terms of the researcher's use of the records and prohibits the publication or release of the names of individual cancer patients or any facts tending to lead to the identification of individual cancer patients.

(2) Notwithstanding division (B)(1) of this section, a researcher may, with the approval of the department, use the names of individual cancer patients when requesting additional information for research purposes or soliciting a patient's participation in a research project. If a researcher requests additional information or a cancer patient's participation in a research project, the researcher shall first obtain the oral or written consent of the patient's attending physician. If the consent of the patient's attending physician is obtained, the researcher shall obtain the patient's written consent by having the patient complete a release of confidential information form.

(3) The department may release confidential information concerning individual cancer patients to physicians for diagnostic and treatment purposes if the patient's attending physician gives oral or written consent to the release of the information and the patient

gives written consent by completing a release of confidential information form.

(4) The department may release confidential information concerning individual cancer patients to the cancer registry of another state, if the other state has entered into a reciprocal agreement with the department and the agreement provides that the state will comply with this section and that information identifying a patient will not be released to any person without the written consent of the patient.

(C) Nothing in this section prevents the release to any person of epidemiological information that does not identify individual cancer patients.

(D) No person shall fail to comply with the confidentiality requirements of this section.

Effective Date: 11-11-1991

3701.264 Ohio cancer incidence surveillance system advisory board.

There is hereby created the Ohio cancer incidence surveillance system advisory board. The board shall consist of the director of health, who shall serve as chair of the board, and one representative, appointed by the governor, from each medical school accredited by the liaison committee on medical education and each osteopathic medical school accredited by the American osteopathic association in Ohio. In addition, the director of health shall appoint up to three additional members of the board. Vacancies on the board shall be filled in the same manner as the initial appointments. Members shall serve without compensation.

The board shall provide oversight of the collection and analysis of data by the cancer surveillance system to the director of health and the Arthur G. James cancer hospital and Richard J. Solove research institute of the Ohio state university and advise in the implementation of sections 3701.261 to 3701.263 of the Revised Code. The board shall meet and conduct its business as directed by the chair.

The board shall report to the finance committees of both houses of the general assembly, not later than March 1, 2001, on the progress made in implementing sections 3701.261 to 3701.263 of the Revised Code.

The board is not subject to sections 101.82 to 101.87 of the Revised Code.

Effective Date: 03-22-2001

3701.99 Penalty.

(A) Whoever violates division (C) of section 3701.23, division (C) of section 3701.232, division (C) of section 3701.24, division (B) of section 3701.25, division (I) of section 3701.262, division (D) of section 3701.263, or sections 3701.46 to 3701.55 of the Revised Code is guilty of a minor misdemeanor on a first offense; on each subsequent offense, the person is guilty of a misdemeanor of the fourth degree.

(B) Whoever violates section 3701.82 of the Revised Code is guilty of a misdemeanor of the first degree.

(C) Whoever violates section 3701.352 or 3701.81 of the Revised Code is guilty of a misdemeanor of the second degree. Effective Date: 02-12-2004

Chapter 3701-4 Ohio Cancer Incidence Surveillance System

3701-4-01 Definitions.

As used in rules 3701-4-01 to 3701-4-03 of the Administrative Code:

(A) "Cancer" means any primary malignant neoplasm with the exception of basal and squamous carcinoma of the skin and carcinoma in situ of the cervix.

(B) "Dentist" means a person who is licensed under section 4715.12 or 4715.15 of the Revised Code to practice dentistry.

(C) "Department" means the department of health.

(D) "Director" means the director of health.

(E) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.

(F) "Ohio cancer incidence surveillance system" means a population based cancer registry maintained at the department pursuant to section 3701.261 of the Revised Code to monitor the incidence of various types of malignant diseases in Ohio, make appropriate epidemiologic studies to determine any causal relations of such disease with occupational, nutritional, environmental, or infectious conditions, and alleviate or eliminate any such conditions

(G) "Physician" means a person who holds a valid certificate issued under Chapter 4731. of the Revised Code.

R.C. 119.032 review dates: 09/01/2005 and 09/01/2010

Promulgated Under: 119.03

Statutory Authority: 3701.262

Rule Amplifies: 3701.262

Prior Effective Dates: 5/20/1993

3701-4-02 Responsibility for reporting.

(A) There is hereby created the Ohio cancer incidence surveillance system. In the development and administration of the Ohio cancer surveillance system the department may use information compiled by public or private cancer registries and may contract for the collection and analysis of, and the research related to, the information recorded under this section.

(B) Each physician, dentist, hospital, or person providing diagnostic or treatment services to

patients with cancer shall report each case of cancer to the department on forms provided by the department or on computer tape or diskette. The report shall contain information regarding the patient which includes but is not limited to the following:

- (1) Last name of patient;
- (2) First name of patient;
- (3) Middle initial of patient;
- (4) Social security number of patient (if available);
- (5) County of residence at diagnosis;
- (6) City of residence at diagnosis;
- (7) Street address at diagnosis;
- (8) State of residence at diagnosis;
- (9) Zip code at diagnosis;
- (10) Birth date;
- (11) Sex;
- (12) Race;
- (13) Hispanic origin;
- (14) Age in years at diagnosis;
- (15) Date of diagnosis;
- (16) Date of first contact for this cancer office, (outpatient or inpatient);
- (17) Source of information;
- (18) Anatomical site of this cancer;
- (19) Laterality of diagnosis;
- (20) Sequence;
- (21) Histology;
- (22) Grade;
- (23) O.C.I.S.S. source reporting code number:-
- (24) American joint committee on cancer edition number;

- (25) Diagnostic confirmation;
- (26) First course of treatment;
- (27) Date treatment began;
- (28) Class of case;
- (29) Occupation and industry;
- (30) Tobacco use;
- (31) Date of death;
- (32) Underlying cause of death;
- (33) Physician's name;
- (34) Stage at diagnosis per american joint committee on cancer;
- (35) Stage at diagnosis per surveillance, epidemiology, and end results;
- (36) Primary site text – from medical reports;
- (37) Histology text – from medical reports;
- (38) Staging text – from medical reports; and
- (39) Treatment text – from medical reports.

Any person required to report pursuant to this paragraph may elect to report to the department through an existing cancer registry if the registry submits the information in accordance with the requirements of this rule.

(C) Each and every physician, dentist, hospital, and other person providing diagnostic services to patients with cancer will report the diagnosis within six months of the date of diagnosis. Facilities or persons providing treatment services to patients with cancer will report the case within six months of the date of first contact with the case patient.

(D) All physicians, dentists, hospitals or persons providing diagnostic or treatment services to patients with cancer shall grant to the department or its authorized representative access to all records that identify cases of cancer or establish characteristics of cancer, the treatment of cancer, or the medical status of any identified cancer patient.

(E) Furnishing information, including records, reports, statements, notes, memoranda, or other information, to the department of health either voluntarily or as required by this rule, or to a person or governmental entity designated as a medical research project by the department does not subject a physician, dentist, hospital, or person providing diagnostic or treatment services to patients with cancer to liability in an action for damages, or other relief for furnishing the information.

(F) This rule does not affect the authority of any person or facility providing diagnostic or

treatment services to patients with cancer to maintain facility-based tumor registries, in addition to complying with the reporting requirements of this rule.

R.C. 119.032 review dates: 09/01/2005 and 09/01/2010

Promulgated Under: 119.03

Statutory Authority: 3701.261

Rule Amplifies: 3701.262

Prior Effective Dates: 5/20/1993

3701-4-03 Confidentiality; research.

(A) Any information, data, and reports with respect to a case of malignant disease which are furnished to, or procured by, any cancer registry in this state or the department of health shall be confidential and shall be used only for statistical, scientific, and medical research for the purposes of reducing the morbidity or mortality of malignant disease. No physician, dentist, person, or hospital furnishing such information, data, or report to any such cancer registry or the department of health, with respect to a case of malignant disease treated or examined by such physician, dentist, or person, or confined in such hospital, shall by reason of such furnishing be deemed to have violated any confidential relationship, or be held liable in damages to any person, or be held to answer for willful betrayal of a professional confidence within the meaning and intent of section 4731.22 of the Revised Code.

(B) Information concerning individual cancer patients obtained by the department for the Ohio cancer incidence surveillance system is for the confidential use of the department. However, a person involved with a medical research project may be given access to confidential information if the medical research project meets the standards established in paragraph (C) of this rule and if all the following conditions are met:

- (1) The person conducting the research provides written information about the purpose of the research project, the nature of the data to be collected and how the researcher intends to analyze it, the records the researcher seeks to review, and the safeguards the researcher will take to protect the identity of patients whose records the researcher will be reviewing;
- (2) The person conducting the research submits verification of his credentials and of the credentials of other individuals involved in conducting the research;
- (3) In the view of the director of health, the proposed safeguards are adequate to protect the identity of each patient whose records will be reviewed. Safeguards for the protection of the identity of patients shall include, but are not limited to, provisions to limit access to identifying data to only those individuals who during the course of the project need access to such information for research purposes and provisions for the maintenance of the confidentiality of identifying information after the termination of the project;
- (4) An agreement is executed between the department and the researcher that specifies the terms of the researcher's use of the records and prohibits the publication or release of the names of individual cancer patients or any facts tending to lead to the identification of individual cancer patients.

(C) Based on the written information submitted to the director pursuant to paragraph (B) of this rule, the director shall determine that access to confidential information concerning individual cancer patients shall be made available to a person involved in a medical research project if the medical research project meets the following standards:

(1) The medical research project has clearly defined goals that pertain to cancer prevention and control;

(2) For case control studies, the research design used in the medical research project will involve a sufficiently large sample size that any meaningful difference between cases and controls will be statistically significant. For other studies, the research project will provide enough cases for meaningful analysis of the data for identification of potential risk factors and intervention strategies for cancer prevention and control; and

(3) The medical research project will be conducted at a university, hospital, or other medical research institution by competent researchers who have the ability to analyze and interpret data.

(D) Notwithstanding paragraphs (A) and (B) of this rule, a researcher may, with the approval of the department, use the names of individual cancer patients when requesting additional information for research purposes or soliciting a patient's participation in a research project. If a researcher requests additional information or a cancer patient's participation in a research project, the researcher shall first obtain the oral or written consent of the patient's attending physician. If the consent of the patient's attending physician is obtained, the researcher shall obtain the patient's written consent by having the patient complete a release of confidential information form.

(E) Notwithstanding paragraphs (A) and (B) of this rule, the department may release confidential information concerning individual cancer patients to physicians for diagnostic and treatment purposes if the patient's attending physician gives oral or written consent to the release of the information and the patient gives written consent by completing a release of confidential information form.

(F) Notwithstanding paragraph (A) and (B) of this rule the department may release confidential information concerning individual cancer patients to the cancer registry of another state, if the other state has entered into a reciprocal agreement with the department and the agreement provides that the state will comply with this section and that information identifying a patient will not be released to any person without the written consent of the patient.

(G) Nothing in this rule prevents the release to any person of epidemiological information that does not identify individual cancer patients.

R.C. 119.032 review dates: 09/01/2005 and 09/01/2010

Promulgated Under: 119.03

Statutory Authority: 3701.262

Rule Amplifies: 3701.263

Prior Effective Dates: 5/20/1993

APPENDIX 2

How to Use Ambiguous Terminology for Case Ascertainment

***SEER Program and Staging Manual 2004, Revision 1, Released August 14,
2006***

How to use Ambiguous Terminology for Case Ascertainment*

1. **In Situ and Invasive** (Behavior codes /2 and /3)

- a. If any of the reportable **ambiguous terms precede** a word that is **synonymous** with an in situ or invasive tumor (e.g.: cancer, carcinoma, malignant neoplasm, etc.), the case is reportable. Accession the case.

Example: The pathology report says: “Prostate biopsy with markedly abnormal cells that are typical of adenocarcinoma.” Accession the case.

Negative Example: The final diagnosis on the outpatient report reads: “Rule out leukemia.” DO NOT accession the case.

- b. **Discrepancies:** If one section of the medical record(s) uses a reportable term such as “apparently” and another section of the medical record(s) uses a non-reportable term such as “can not be ruled out”, accept the reportable term and accession the case.

Exception: Do not accession a case based solely on suspicious cytology. The case is accessioned if proven by positive cytology or other diagnostic methods including a physician’s clinical diagnosis. (See the data item Diagnostic Confirmation for methods of diagnosis.)

Note: If the **word or an equivalent term does not appear** on either the reportable or not reportable list or is not a form of a word on the reportable list, the term is NOT diagnostic of cancer. DO NOT accession the case. Forms of the word are such as: “Favored” rather than “Favor(s)”; “appeared to be” rather than “appears”. DO NOT substitute synonyms such as “supposed” for “presumed” or “equal” for “comparable”.

- c. Use these terms when **screening** diagnoses on pathology reports, operative reports, scans, mammograms, and other diagnostic testing other than tumor markers.

Note: If the ambiguous diagnosis is **proven to be not reportable** by biopsy, cytology, or physician’s statement, **do not accession** the case.

Example: Mammogram shows calcifications suspicious for intraductal carcinoma. The biopsy of the area surrounding the calcifications is negative for malignancy. DO NOT accession the case.

2. **Benign and borderline primary intracranial and CNS tumors**

- a. Use the “Ambiguous Terms that are Reportable” list to identify benign and borderline primary intracranial and CNS tumors that are reportable.
- b. If any of the reportable **ambiguous terms precede** either the word “**tumor**” or the word “**neoplasm**”, the case is reportable. Accession the case.

Example: The mass on the CT scan is consistent with pituitary tumor. Accession the case.

- c. **Discrepancies:** If one section of the medical record(s) uses a reportable term such as “apparently” and another section of the medical record(s) uses a non-reportable term such as “can not be ruled out”, accept the reportable term and accession the case.

Exception: Do not accession a case based solely on suspicious cytology. The case is accessioned if proven by positive cytology or other diagnostic methods including a physician’s clinical diagnosis. (See the data item Diagnostic Confirmation for methods of diagnosis.)

- d. Use these terms when **screening** diagnoses on pathology reports, scans, ultrasounds, and other diagnostic testing other than tumor markers.

Note: If the **ambiguous** diagnosis is proven to be **not reportable** by biopsy, cytology, or physician’s statement, **do not accession** the cas

SEER Program and Staging Manual 2004, Revision 1, Released August 14, 2006.

APPENDIX 3

Removed by OCISS for Reporting Source Procedure Manual (Version 7)

APPENDIX 4

Removed by OCISS for Reporting Source Procedure Manual (Version 7)

APPENDIX 5

OCISS Individual Cancer Case Reporting Form

Ohio Department of Health Ohio Cancer Incidence Surveillance System (OCISS) Individual Cancer Case Worksheet

Demographic Information

Patient name

(1) Last		
(2) First		
(3) Middle		(4) Suffix (e.g. Jr.)
(5) Maiden		
(6) Alias "AKA"		

General

(7) Social Security number	(10) Place of Birth
(8) Medical Record number	(11) Marital status (at time of diagnosis)
	1—Single (never married) 3—Separated 5—Widowed 2—Married (including common law) 4—Divorced 9—Unknown
(9) Date of Birth (DOB) mm/dd/yyyy	(12) Sex
	1—Male 3—Other (hermaphrodite) 9—Not stated in patient record 2—Female 4—Transsexual

Demographics (At time of diagnosis)

(13) Address (number and street)	(13a) Address supplemental (e.g. PO Box)				
(14) City	(15) State				
(15) ZIP/Postal code	(17) County				
(18) Race 1	(19) Race 2	(20) Race 3	(21) Race 4	(22) Race 5	(23) Hispanic (Spanish/Hispanic origin)

Race codes

01—White	05—Japanese	14—Thai	22—Guamanian, NOS	88—No additional races for race 2
02—Black	06—Filipino	15—Asian Indian or Pakistani, NOS (formerly code 09)	25—Polynesian, NOS	96—Other Asian, including Asian, NOS and Oriental, NOS
03—American Indian, Aleutian or Eskimo (includes all indigenous populations of the western hemisphere)	07—Hawaiian	16—Asian Indian	26—Tahitian	97—Pacific Islander, NOS
04—Chinese	08—Korean	17—Pakistani	27—Samoan	98—Other
	10—Vietnamese	20—Micronesian, NOS	28—Tongan	99—Unknown
	11—Laotian	21—Chamorroan	30—Melanesian, NOS	
	12—Hmong		31—Fiji Islander	
	13—Kampuchean (Cambodian)		32—New Guinean	

Hispanic codes

0—Non-Spanish; non-Hispanic	6—Spanish, NOS; Hispanic, NOS; Latino, NOS (There is evidence other than surname or maiden name that the person is Hispanic, but he/she cannot be assigned to any category of 1–5).
1—Mexican (includes Chicano)	7—Spanish surname only (The only evidence of the person's Hispanic origin is surname or maiden name, and there is no contrary evidence that the person is not Hispanic).
2—Puerto Rican	8—Dominican Republic (for use with patients who were diagnosed with cancer January 1, 2005, or later).
3—Cuban	9—Unknown whether Spanish or not; not stated in patient record
4—South or Central American (except Brazil)	
5—Other specified Spanish/Hispanic origin, (includes European; excludes Dominican Republic).	

Environment (Greatest lifetime)

(24) **Usual occupation** (Text) (Work performed during most of the patient's working life before diagnosis of this tumor)

(25) **Usual industry** (Text) (Business/industry where patient was employed for most years of working life before diagnosis of this tumor)

(26) **Tobacco history**

0—Never used
1—Cigarette smoker, current (or quit within past year)
2—Cigar/pipe smoker, current (or quit within past year)
 3—Snuff/chew/smokeless, current (or quit within past year)
4—Combination use, current (or quit within past year)
5—Previous use (no use within past year)
 9—Unknown

Diagnostic Information

(27) **Date of diagnosis** mm/dd/yyyy

- -

(28) **Primary site** (ICD-O Third Edition coding)

C .

(29) **Laterality at diagnosis**

0—Organ is not a paired site
1—Origin of primary is right
2—Origin of primary is left
 3—Only one side involved, right or left origin not specified
4—Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms tumors
 5—Paired site: midline tumor
6—Paired site: but no information concerning laterality

(30) **Primary site** (Substantiating text)

(31) **Histology/Behavior** (ICD-O Third Edition coding)

M

(32) **Histology/Behavior** (Substantiating text)

(33) **Grade** (Differentiation)

Grade I, 1, i —Well differentiated, differentiated, NOS
Grade II, 2, ii I/III or 1/3 —Moderately differentiated; moderately well differentiated; intermediate differentiation
 Grade III, 3, iii II/III or 2/3 —Poorly differentiated; dedifferentiated
Grade IV, 4, iv III/III or 3/3 —Undifferentiated; anaplastic
9—Unknown grade

(33a) **Grade path system**

Blank—No 2, 3 or 4 grade system available. Unknown.
2—A 2-grade grading system was used (2, II or ii)
 3—A 3-grade grading system was used (3, III or iii)
4—A 4-grade grading system was used (4, IV or iv)

(33b) **Grade path value**

Blank— No 2-, 3- or 4-grade system available. Unknown.
1 — Recorded as Grade I, i, or 1 of 2-4 grade system
2 — Recorded as Grade II, ii, or 2 of 2-4 grade system
 3 — Recorded as Grade III, iii, or 3 of 3-4 grade system
4 — Recorded as Grade IV, iv, or 4 of 4 grade system

(34) **Diagnostic confirmation**

1—Positive histology
2—Positive cytology
4—Positive microscopic confirmation, method not specified
5—Positive laboratory test or marker study
 6—Direct visualization without microscopic confirmation
7—Radiology and other imaging techniques without microscopic confirmation
8—Clinical diagnosis only (other than 5, 6 or 7)
9—Unknown whether or not microscopically confirmed

(35) **Vital status**

0—Dead
1—Alive

(36) **Date of last contact** (at this facility) mm/dd/yyyy

- -

(39) **Sequence number** (See FORDS manual for codes)

(40) **Date of first contact** (at this facility) mm/dd/yyyy

- -

(41) **Class of case**

Class of case codes

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 a 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.

Patient appears in person at reporting facility

- 30 —Initial diagnosis and all first course treatment provided elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, staging workup after initial diagnosis elsewhere).
- 31 —Initial diagnosis and all first course treatment provided elsewhere AND reporting facility providing in-transit care.
- 32 —Diagnosis AND all first course treatment provided elsewhere AND patient 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 (for example, a benign colon tumor) AND initial diagnosis AND part or all of the first course treatment by reporting facility.
- 35 —Case diagnosis before program's Reference Date AND initial diagnosis AND all or part first course of treatment provided by reporting facility.
- 36 —Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND all or part of the 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

- 40 —Diagnosis AND all first course treatment given at the same staff physician's office.
- 41 —Diagnosis and all first course of treatment given in two or more different staff physician offices.
- 42 —Non-staff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility).
- 43 —Pathology or other lab specimens only.
- 49 —Death certificate only.
- 99 —Non analytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases).

Diagnostic Procedures

(41a) Diagnostic Procedure code

- 00 —No surgical diagnostic or staging procedure was performed.
- 01 —A biopsy was done to a site other than the primary site.
No exploratory procedure was done.
- 02 —A biopsy was done to a site to the primary site, or biopsy or removal of a lymph node to diagnose or stage lymphoma.
- 03 —A surgical exploratory 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 of whether a diagnostic or staging procedure was performed.

(41b) Date of Diagnostic Procedure mm/dd/yyyy

 - -

(41c) Date of Diagnostic Procedure Flag

- 10—No information whatsoever can be inferred from this exceptional value (that is, unknown if any diagnostic or staging procedure performed).
- 11—No proper value is applicable in this context (for example, no diagnostic or staging procedure performed; autopsy only case).
- 12—A proper value is applicable but not known. This event occurred, but the date is unknown (for example, diagnostic or staging procedure performed but date is unknown).
- Blank—A valid date is provided in item *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280). Case was diagnosed prior to January 1, 2007.

(42) Physical exam (Results of the physical exam) (Text)

(43) X-ray/Scans (Results of X-rays, scans and/or other imaging examinations) (Text)

(44) Endoscopic (Text)

(45) Laboratory (Results of laboratory examinations other than cytology or histopathology) (Text)

(46) Surgical (Results of all surgical procedures) (Text)

(47) Pathology (Text)

(58) **Hormone therapy code**

- 00—None, hormone therapy was not part of the planned first course of therapy. Diagnosed at autopsy.
- 01—Hormone therapy administered as first course therapy.
- 82—Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration, etc.).
- 85—Hormone therapy was not administered because patient died prior to planned or recommended therapy.
- 86—Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
- 87—Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member or patient's guardian. The refusal was noted in patient record.
- 88—Hormone therapy was recommended, but it is unknown if administered.
- 99—It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in the patient record. Death certificate only.

(59) **Hormone therapy start date** mm/dd/yyyy

 - -

(59a) **Hormone flag** (Complete if date hormone started is unavailable)

- 10—No information whatsoever can be inferred from this exceptional value (that is, unknown if any hormone therapy was given).
- 11—No proper value is applicable in this context (for example, no hormone therapy was given).
- 12—A proper value is applicable but not known. This event occurred, but the date is unknown (that is, hormone therapy 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, hormone therapy is planned as part of the first course of therapy, but not yet started at the time of the last follow-up).
- Blank**—A valid date value is provided in item *Date Hormone Therapy Started* (NAACCR Item #1230). Case was diagnosed between 2003 and 2009 and the facility did not record *Date Hormone Therapy Started* (NAACCR Item #1230) at that time.

(60) **Hormone therapy (Text)**

(61) **BRM immunotherapy code**

- 00—None, immunotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
- 01—Immunotherapy therapy administered as first course therapy.
- 82—Immunotherapy therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration, etc.).
- 85—Immunotherapy therapy was not administered because patient died prior to planned or recommended therapy.
- 86—Immunotherapy therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
- 87—Immunotherapy therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member or patient's guardian. The refusal was noted in patient record.
- 88—Immunotherapy therapy was recommended, but it is unknown if administered.
- 99—It is unknown whether a immunotherapeutic agent(s) was recommended or administered because it is not stated in the patient record. Death certificate only.

(62) **BRM immunotherapy start date** mm/dd/yyyy

 - -

(62a) **BRM immunotherapy flag** (Complete if date immunotherapy started is unavailable)

- 10—No information can be inferred from this exceptional value (that is, unknown if any immunotherapy therapy was given).
- 11—No proper value is applicable in this context (for example, no immunotherapy was given).
- 12—A proper value is applicable but not known. This event occurred, but the date is unknown (that is, immunotherapy 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, immunotherapy is planned as part of the first course of therapy, but not yet started at the time of the last follow-up).
- Blank**—A valid date value is provided in item *Date Immunotherapy Started* (NAACCR Item #1240). Case was diagnosed between 2003 and 2009 and the facility did not record *Date Immunotherapy Started* (NAACCR Item #1240) at that time.

(63) **BRM (Text)**

(64) **Other treatment code**

- | | | |
|----------------------|----------------------|--|
| 0—None | 3—Other—Double Blind | 8—Recommended; unknown if administered |
| 1—Other | 6—Other—Unproven | 9—Unknown |
| 2—Other—Experimental | 7—Refusal | |

(65) **Date other treatment started** mm/dd/yyyy

 - -

(65a) **Other treatment flag** (Complete if date hormone started is unavailable)

- 10—No information whatsoever can be inferred from this exceptional value (that is, unknown if any other treatment was given).
- 11—No proper value is applicable in this context (for example, no other treatment was given).
- 12—A proper value is applicable but not known. This event occurred, but the date is unknown (that is, other treatment was given but the date is unknown).
- Blank**—A valid date value is provided in item *Date Other Treatment Started* (NAACCR Item #1250).

(66) **Other treatment (Text)**

(67) Radiation/surgery sequence

- | | | |
|---|---|---|
| 0—No radiation therapy and/or surgical procedures | 4—Radiation therapy both before and after surgery | 6—Intraoperative radiation therapy with other therapy administered before and after surgery |
| 2—Radiation therapy before surgery | 5—Intraoperative radiation therapy | 9—Sequence unknown |
| 3—Radiation therapy after surgery | | |

(68) Radiation regional RX modality

- | | | |
|--------------------------------|--|-------------------------------------|
| 00—No radiation treatment | 30—Neutrons, with or without photons/electrons | 53—Brachytherapy, interstitial, LDR |
| 20—External beam, NOS | 31—IMRT | 54—Brachytherapy, interstitial, HDR |
| 21—Orthovoltage | 32—Conformal or 3-D therapy | 55—Radium |
| 22—Cobalt-60, Cesium-137 | 40—Protons | 60—Radioisotopes, NOS |
| 23—Photons (2-5 MV) | 41—Stereotactic radiosurgery, NOS | 61—Strontium-89 |
| 24—Photons (6-10 MV) | 42—Linac radio surgery | 62—Strontium-90 |
| 25—Photons (11-19 MV) | 43—Gamma Knife | 80—Combined modality specified* |
| 26—Photons (> 19 MV). | 50—Brachytherapy, NOS | 85—Combined modality, NOS* |
| 27—Photons (mixed energies). | 51—Brachytherapy, intracavity, LDR | 98—Other, NOS |
| 28—Electrons | 52—Brachytherapy, intracavity, HDR | 99—Unknown |
| 29—Photons and electrons mixed | | |

(68a) Reason for no radiation

- | | |
|--|--|
| 0—Radiation therapy was administered. | physician, but was not administered as part of the first course treatment. No reason was noted in patient record. |
| 1—Radiation therapy was not administered because it was not part of the planned first course treatment. | 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 the patient record. |
| 2—Radiation therapy was not recommend/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiations, etc.). | 8—Radiation therapy was recommended, but it is unknown whether it was administered. |
| 5—Radiation therapy was not administered because the patient died prior to planned or recommended therapy. | 9—It is unknown if radiation therapy was recommended or administered. Death certificate and autopsy cases only. |
| 6—Radiation therapy was not administered; it was recommended by the patient's | |

(69) RX Summ systemic/surgery sequence

- | | |
|--|--|
| 0—No systemic therapy and/or surgical procedures | 5—Intraoperative systemic therapy |
| 2—Systemic therapy before surgery | 6—Intraoperative systemic therapy with other systemic therapy administered before or after surgery |
| 3—Systemic therapy after surgery | 9—Sequence unknown. |
| 4—Systemic therapy both before and after surgery | |

(70) RX Summ transplant/endocrine

- | | |
|---|---|
| 00—No transplant procedure or endocrine therapy was administered as part of the first course of therapy. Diagnosed at autopsy. | administered because the patient died prior to planned or recommended therapy. |
| 10—A bone marrow transplant procedure was administered, but the type was not specified. | 86—Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but it was not administered as part of the first course of therapy. No reason was stated in patient record. |
| 11—A bone marrow transplant—autologous. | 87—Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record. |
| 12—A bone marrow transplant—allogenic. | 88—Hematologic transplant and/or endocrine surgery/radiation was recommended but it is unknown if it was administered. |
| 20—Stem cell harvest and infusion. Umbilical cord stem cell transplant. | 99—It is unknown whether hematologic transplant and /or endocrine surgery/ radiation was recommended or administered because it was not stated in patient record. Death certificate only. |
| 30—Endocrine surgery and/or endocrine radiation therapy. | |
| 40—Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12, or 20). | |
| 82—Hematologic transplant and/or endocrine surgery/radiation was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of disease prior to administration, etc.). | |
| 85—Hematologic transplant and/or endocrine surgery/radiation was not | |

(71) Surgical margins (Surgical margins of the primary site)

- | | | |
|------------------------------|------------------------------|-----------------------------|
| 0—No residual tumor | 3—Macroscopic residual tumor | 8—No primary site surgery |
| 1—Residual tumor, NOS | 7—Margins not evaluable | 9—Unknown or not applicable |
| 2—Microscopic residual tumor | | |

(72) Scope of regional lymph node surgery

- | | |
|--|---|
| 0—None | 4—1-3 regional lymph nodes removed |
| 1—Biopsy or aspiration of regional lymph node, NOS | 5—4 or more regional lymph nodes removed |
| 2—Sentinel lymph node biopsy | 6—Sentinel node biopsy and code 3, 4, or 5 at same time, or timing not stated |
| 3—Number of regional nodes removed unknown or not stated; regional lymph nodes, removed, NOS | 7—Sentinel node biopsy and code 3, 4, or 5 at different times |
| | 9—Unknown or not applicable |

(73) Surgery of other regional site(s), or distant lymph nodes

- | | |
|---|---|
| 0—None | 4—Nonprimary surgical procedure to distant site |
| 1—Nonprimary surgical procedure performed | 5—Combination of codes |
| 2—Nonprimary surgical procedure to other regional sites | 9—Unknown |
| 3—Nonprimary surgical procedure to <i>distant lymph node(s)</i> | |

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

(74) If no cancer directed surgery, reason for no surgery

- 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 (i.e., comorbid conditions, advanced age, progression of tumor prior to planned surgery, etc.).
- 5—Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
- 6—Surgery of the primary site was not performed it was recommended by

- the patient's physician, but was not performed as part of the first-course therapy. No reason was noted in patient record.
- 7—Surgery of the primary site was not performed; 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 the patient record.
- 8—Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
- 9—It is unknown whether surgery of the primary site was recommended or performed. Diagnosed at autopsy or death certificate only.

Physicians

(75) Physician—managing license number

Input field for (75) Physician—managing license number

(76) NPI—managing physician (Populated by OCISS)

Input field for (76) NPI—managing physician

(77) Physician—follow-up license number

Input field for (77) Physician—follow-up license number

(78) NPI—following physician (Populated by OCISS)

Input field for (78) NPI—following physician

(79) Physician—primary surgeon license number

Input field for (79) Physician—primary surgeon license number

(80) NPI—primary surgeon (Populated by OCISS)

Input field for (80) NPI—primary surgeon

Collaborative Stage Inputs – For cases diagnosed ON or AFTER 1/1/2004

(See the Collaborative Staging Manual and Coding Instructions, Version 02.00.00 for Site-Specific codes and coding rules)

(85) CS tumor size

Input field for (85) CS tumor size

(Record the largest dimension, or the diameter of the primary tumor in millimeters).

(86) CS extension

Input field for (86) CS extension

(Identifies contiguous growth (extension) of the primary tumor within the organ of origin or its extension into neighboring organs).

(87) CS tumor size/extension evaluated

Input field for (87) CS tumor size/extension evaluated

Identifies whether the T, of AJCC TNM, was clinically or pathologically diagnosed and by what method.

(87a) Lymph vascular invasion

Input field for (87a) Lymph vascular invasion

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

(88) CS lymph nodes

Input field for (88) CS lymph nodes

(Identifies the regional lymph nodes involved with cancer at the time of diagnosis.)

(89) CS Regional lymph nodes evaluated

Input field for (89) CS Regional lymph nodes evaluated

This field is primarily used to derive the staging Basis for N category in the TNM system. It records the code for the item CS Lymph Nodes was determined based on the diagnostic methods employed.

(90) CS regional LN positive

Input field for (90) CS regional LN positive

(Identifies the number of regional LN's positive at the time of diagnosis.

(91) CS regional LN examined

Input field for (91) CS regional LN examined

(Number of Regional LN's that were examined)

(92) CS Metastasis at diagnosis

Input field for (92) CS Metastasis at diagnosis

Identifies the distant sites(s) of metastatic involvement at time of diagnosis

(93) CS metastasis evaluated

Input field for (93) CS metastasis evaluated

This item reflect the validity of the classification of this item CS Mets at DX only According to the diagnostic methods employed.

CS Site-Specific Factors for tumors diagnosed in 2010 (See FORDS Manual for codes)

(94) Site Specific Factor 1

Input field for (94) Site Specific Factor 1

(95) Site Specific Factor 2

Input field for (95) Site Specific Factor 2

(96) Site Specific Factor 3

Input field for (96) Site Specific Factor 3

(97) Site Specific Factor 4

Input field for (97) Site Specific Factor 4

(98) Site Specific Factor 5

Input field for (98) Site Specific Factor 5

(99) Site Specific Factor 6

Input field for (99) Site Specific Factor 6

(99a) Site Specific Factor 7

Input field for (99a) Site Specific Factor 7

(99b) Site Specific Factor 8

Input field for (99b) Site Specific Factor 8

(99c) Site Specific Factor 9

Input field for (99c) Site Specific Factor 9

(99d) Site Specific Factor 10

Input field for (99d) Site Specific Factor 10

(99e) Site Specific Factor 11

Input field for (99e) Site Specific Factor 11

(99f) Site Specific Factor 12

Input field for (99f) Site Specific Factor 12

(99g) Site Specific Factor 13

Input field for (99g) Site Specific Factor 13

(99h) Site Specific Factor 14

Input field for (99h) Site Specific Factor 14

(99i) Site Specific Factor 15

Input field for (99i) Site Specific Factor 15

(99j) Site Specific Factor 16

Input field for (99j) Site Specific Factor 16

(99k) Site Specific Factor 17 <input type="text"/>	(99l) Site Specific Factor 18 <input type="text"/>	(99m) Site Specific Factor 19 <input type="text"/>	(99n) Site Specific Factor 20 <input type="text"/>
(99o) Site Specific Factor 21 <input type="text"/>	(99p) Site Specific Factor 22 <input type="text"/>	(99q) Site Specific Factor 23 <input type="text"/>	(99r) Site Specific Factor 24 <input type="text"/>
(99s) Site Specific Factor 25 <input type="text"/>			

Staging (For CANCER diagnosed ON or AFTER 1/1/2001 and PRIOR to 1/1/2004 and were assigned a (SEER) Summary Surveillance, Epidemiology and End Results Program (SEER) Summary Stage 2000

(100) SEER Summary Stage 2000 <input type="text"/>	0—In situ. 1—Localized. 2—Regional by direct extension.	3—Regional by lymph nodes 4—Regional (both codes 2 and 3) 5—Regional, NOS	7—Distant metastasis/systemic disease 9—Unknown of extension or metastasis (unstaged, unknown, or unspecified); death certificate only
---	---	---	---

(101) Staging Text

(102) Size of tumor (mm) <input type="text"/>	(103) Number of Regional Nodes Examined (EOD) <input type="text"/>	(104) Number of Regional Nodes Positive (EOD) <input type="text"/>
--	---	---

AJCC staging for cases Diagnosed on or After 1/1/2001 and Prior to 1/1/2004 (American Joint Committee on Cancer Staging Manual)(See AJCC Cancer Staging Manual Seventh Edition)

(105) AJCC Clinical tumor <input type="text"/>	(Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known prior to the start of therapy)	(106) AJCC Clinical node <input type="text"/>	(Identifies the absences or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known prior to the start of any therapy)
---	---	--	---

(107) AJCC Clinical metastasis <input type="text"/>	(Identifies the presence or absence of distant metastasis (M) of the tumor known prior to the start of any therapy)	(108) AJCC Clinical TNM stage group <input type="text"/>	(Identifies the anatomic extent of disease based on the T,N, and M elements known prior to the start of any therapy)
--	---	---	--

(109) AJCC Clinical group text (Substantiating)

(110) Clinical stage descriptor (AJCC) as recorded by the physician <input type="text"/>	0—None 1—E (Extranodal, lymphomas only) 2—S (Spleen, lymphomas only)	3—M (Multiple primary tumors in a single site) 5—E and S (Extranodal and spleen, lymphomas only)	6—M and Y (Multiple primary tumors and initial multimodality therapy) 9—Unknown, not stated in patient record
---	--	---	--

(111) Clinical stage recorded by (Identifies the person who recorded the clinical AJCC staging elements) <input type="text"/>	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 physician	7—Staging assigned at another facility 8—Case is not eligible for staging 9—Unknown; not stated in patient record
--	---	---	---

(112) AJCC stage pathological tumor <input type="text"/>	(Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known following the completion of surgical therapy).	(113) AJCC stage pathological node <input type="text"/>	(Identifies the absences or presence of regional lymph node(N) metastasis and describes the extent of regional lymph node metastasis of the tumor known following the completion of surgical therapy).
---	---	--	--

(114) AJCC stage pathological metastasis <input type="text"/>	(Identifies the presence or absence of distant metastasis(M) of the tumor know following the completion of surgical therapy).	(115) AJCC stage pathological group <input type="text"/>	(Identifies the anatomic extent of disease based on the T,N, and M elements known prior to the start of any therapy).
--	---	---	---

(116) AJCC Stage pathological text (Substantiating)

(117) Pathological stage descriptor (AJCC) as recorded by the physician <input type="text"/>	0—None 1—E (Extranodal, lymphomas only) 2—S (Spleen, lymphomas only)	3—M (Multiple primary tumors in a single site) 4—Y (Classification during or after initial multimodality therapy)—pathologic staging only	5—E and S (Extranodal and spleen, lymphomas only) 6—M and Y (Multiple primary tumors and initial multimodality therapy) 9—Unknown, not stated in patient record
---	--	--	---

(118) AJCC pathological stage by (Identifies the person who recorded the pathologic AJCC staging elements) <input type="text"/>	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 physician	7—Staging assigned at another facility 8—Case is not eligible for staging 9—Unknown; not stated in patient record
--	---	---	---

Reporting Source information

(119) Type of reporting source

- | | | | |
|----------------------|--|---|------------------------------------|
| <input type="text"/> | 1—Hospital inpatient | 3—Laboratory only (hospital –affiliated or independent) | 6—Autopsy only |
| <input type="text"/> | 2—Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent) | 4—Physician's office/private medical practitioner (LMD) | 7—Death certificate only |
| | | 5—Nursing/convalescent home/hospice | 8—Other hospital out patient units |

Facility reporting source number

Enter your unique four-digit number of the reporting facility that is assigned by the Ohio Cancer Incidence Surveillance System (OCISS)

(120) Primary payer at diagnosis codes

- | | | | |
|----------------------|---|---|---------------------------------------|
| <input type="text"/> | 01—Not insured | 35—Medicaid administered through as managed care plan | 64—Medicare with Medicaid eligibility |
| <input type="text"/> | 02—Not insured, self-pay | 60—Medicare without supplement, Medicare, NOS | 65—TRICARE |
| | 10—Insurance, NOS | 61—Medicare with supplement, NOS | 66—Military |
| | 20—Private insurance: Managed Care, HMO, or PPO | 62—Medicare administered through a Managed Care plan | 67—Veterans Affairs |
| | 21—Private insurance: Fee-for-Service | 63—Medicare with private supplement | 68—Indian/Public Health Service |
| | 31—Medicaid | | 99—Insurance status unknown |

(121) Initials of person who abstracted this case (abstracted by)

Please check to make sure ALL boxes are completed with appropriate codes and dates.

Please ATTACH supporting documentation, e.g. pathology reports, X-rays, labs, etc.

If you have questions regarding this form please contact your OCISS Regional Representative.

APPENDIX 6

Cancer Case Transmittal Form

APPENDIX 7

Facility Oncology Registry Data Standards (FORDS): Revised for 2010

APPENDIX B: Site-Specific Surgery Codes

http://www.facs.org/cancer/coc/fords/FORDS_for_2010d_05012010.pdf

APPENDIX B:

Site-Specific Surgery Codes

ORAL CAVITY

**Lip C00.0–C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0–C02.9,
Gum C03.0–C03.9, Floor of Mouth C04.0–C04.9, Palate C05.0–C05.9,
Other Parts of Mouth C06.0–C06.9**

(Except for M9727,9733,9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

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

20 Local tumor excision, NOS

26 Polypectomy

27 Excisional biopsy

Any combination of 20 or 26–27 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

25 Laser excision

30 Wide excision, NOS

Code 30 includes:

Hemiglossectomy

Partial glossectomy

40 Radical excision of tumor, NOS

41 Radical excision of tumor ONLY

42 Combination of 41 WITH resection in continuity with mandible (marginal, segmental, hemi- or total resection)

43 Combination of 41 WITH resection in continuity with maxilla (partial, subtotal or total resection)

Codes 40–43 include:

Total glossectomy

Radical glossectomy

Specimen sent to pathology from surgical events 20–43.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

PAROTID AND OTHER UNSPECIFIED GLANDS

Parotid Gland C07.9, Major Salivary Glands C08.0–C08.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

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

20 Local tumor excision, NOS

26 Polypectomy

27 Excisional biopsy

Any combination of 20 or 26–27 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

25 Laser excision

Specimen sent to pathology from surgical events 20–27.

30 Less than total parotidectomy, NOS; less than total removal of major salivary gland, NOS

31 Facial nerve spared

32 Facial nerve sacrificed

33 Superficial lobe ONLY

34 Facial nerve spared

35 Facial nerve sacrificed

36 Deep lobe (Total)

37 Facial nerve spared

38 Facial nerve sacrificed

40 Total parotidectomy, NOS; total removal of major salivary gland, NOS

41 Facial nerve spared

42 Facial nerve sacrificed

50 Radical parotidectomy, NOS; radical removal of major salivary gland, NOS

51 WITHOUT removal of temporal bone

52 WITH removal of temporal bone

53 WITH removal of overlying skin (requires graft or flap coverage)

80 Parotidectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

PHARYNX

Tonsil C09.0–C09.9, Oropharynx C10.0–C10.9, Nasopharynx C11.0–C11.9

Pyriiform Sinus C12.9, Hypopharynx C13.0–C13.9, Pharynx C14.0

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

15 Stripping

No specimen sent to pathology from surgical events 10–15.

20 Local tumor excision, NOS

26 Polypectomy

27 Excisional biopsy

Any combination of 20 or 26–27 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

25 Laser excision

28 Stripping

Specimens sent to pathology from surgical events 20–28.

30 Pharyngectomy, NOS

31 Limited/partial pharyngectomy; tonsillectomy, bilateral tonsillectomy

32 Total pharyngectomy

40 Pharyngectomy WITH laryngectomy OR removal of contiguous bone tissue, NOS (does NOT include total mandibular resection)

41 WITH Laryngectomy (laryngopharyngectomy)

42 WITH bone

43 WITH both 41 and 42

50 Radical pharyngectomy (includes total mandibular resection), NOS

51 WITHOUT laryngectomy

52 WITH laryngectomy

Specimen sent to pathology from surgical events 20–52.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

ESOPHAGUS
C15.0–C15.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

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

20 Local tumor excision, NOS

26 Polypectomy

27 Excisional biopsy

Any combination of 20 or 26–27 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

25 Laser excision

30 Partial esophagectomy

40 Total esophagectomy, NOS

50 Esophagectomy, NOS WITH laryngectomy and/or gastrectomy, NOS

51 WITH laryngectomy

52 WITH gastrectomy, NOS

53 Partial gastrectomy

54 Total gastrectomy

55 Combination of 51 WITH any of 52–54

80 Esophagectomy, NOS

Specimen sent to pathology from surgical events 20-80

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

**STOMACH
C16.0–C16.9**

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

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

20 Local tumor excision, NOS

26 Polypectomy

27 Excisional biopsy

Any combination of 20 or 26–27 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

25 Laser excision

30 Gastrectomy, NOS (partial, subtotal, hemi-)

31 Antrectomy, lower (distal-less than 40% of stomach)***

32 Lower (distal) gastrectomy (partial, subtotal, hemi-)

33 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

Code 30 includes:

Partial gastrectomy, including a sleeve resection of the stomach

Billroth I: anastomosis to duodenum (duodenostomy)

Billroth II: anastomosis to jejunum (jejunostomy)

40 Near-total or total gastrectomy, NOS

41 Near-total gastrectomy

42 Total gastrectomy

A total gastrectomy may follow a previous partial resection of the stomach.

50 Gastrectomy, NOS WITH removal of a portion of esophagus

51 Partial or subtotal gastrectomy

52 Near total or total gastrectomy

Codes 50–52 are used for gastrectomy resection when only portions of esophagus are included in procedure.

- 60 Gastrectomy with a resection in continuity with the resection of other organs, NOS***
- 61 Partial or subtotal gastrectomy, in continuity with the resection of other organs***
- 62 Near total or total gastrectomy, in continuity with the resection of other organs***
- 63 Radical gastrectomy, in continuity with the resection of other organs***

Codes 60–63 are used for gastrectomy resections with organs other than esophagus.

Portions of esophagus may or may not be included in the resection.

80 Gastrectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

*** Incidental splenectomy NOT included

**COLON
C18.0–C18.9**

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

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

20 Local tumor excision, NOS

27 Excisional biopsy

26 Polypectomy, NOS

28 Polypectomy-endoscopic

29 Polypectomy-surgical excision

Any combination of 20 or 26–29 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

25 Laser excision

30 Partial colectomy, segmental resection

32 Plus resection of contiguous organ; example: small bowel, bladder

40 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)

41 Plus resection of contiguous organ; example: small bowel, bladder

50 Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a portion of the rectum)

51 Plus resection of contiguous organ; example: small bowel, bladder

60 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)

61 Plus resection of contiguous organ; example: small bowel, bladder

70 Colectomy or coloproctectomy with resection of contiguous organ(s), NOS (where there is not enough information to code 32, 41, 51 or 61)

Code 70 includes: Any colectomy (partial, hemicolectomy or total) WITH a resection of any other organs in continuity with the primary site. Other organs may be partially or totally removed. Other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy or pelvic exenteration.

80 Colectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

**RECTOSIGMOID
C19.9**

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser ablation

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

20 Local tumor excision, NOS

26 Polypectomy

27 Excisional biopsy

Combination of 20 or 26–27 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

25 Laser excision

30 Wedge or segmental resection; partial proctosigmoidectomy, NOS

31 Plus resection of contiguous organs; example: small bowel, bladder

Procedures coded 30 include, but are not limited to:

Anterior resection

Hartmann operation

Low anterior resection (LAR)

Partial colectomy, NOS

Rectosigmoidectomy, NOS

Sigmoidectomy

40 Pull through WITH sphincter preservation (colo-anal anastomosis)

50 Total proctectomy

51 Total colectomy

55 Total colectomy WITH ileostomy, NOS

56 Ileorectal reconstruction

57 Total colectomy WITH other pouch; example: Koch pouch

60 Total proctocolectomy, NOS

65 Total proctocolectomy WITH ileostomy, NOS

66 Total proctocolectomy WITH ileostomy and pouch

Removal of the colon from cecum to the rectosigmoid or a portion of the rectum.

70 Colectomy or proctocolectomy resection in continuity with other organs; pelvic exenteration

80 Colectomy, NOS; Proctectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

RECTUM

C20.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

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

20 Local tumor excision, NOS

27 Excisional biopsy

26 Polypectomy

Any combination of 20 or 26–27 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

25 Laser excision

28 Curette and fulguration

30 Wedge or segmental resection; partial proctectomy, NOS

Procedures coded 30 include, but are not limited to:

Anterior resection

Hartmann's operation

Low anterior resection (LAR)

Transsacral rectosigmoidectomy

Total mesorectal excision (TME)

40 Pull through WITH sphincter preservation (coloanal anastomosis)

50 Total proctectomy

Procedure coded 50 includes, but is not limited to:

Abdominoperineal resection (Miles Procedure)

60 Total proctocolectomy, NOS

70 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration

80 Proctectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

ANUS
C21.0–C21.8

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

15 Thermal Ablation

No specimen sent to pathology from surgical events 10–15.

20 Local tumor excision, NOS

26 Polypectomy

27 Excisional biopsy

Any combination of 20 or 26–27 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

25 Laser excision

60 Abdominal perineal resection, NOS (APR; Miles procedure)

61 APR and sentinel node excision

62 APR and unilateral inguinal lymph node dissection

63 APR and bilateral inguinal lymph node dissection

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

Specimen sent to pathology from surgical events 20–63.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

LIVER AND INTRAHEPATIC BILE DUCTS

C22.0–C22.1

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

15 Alcohol (Percutaneous Ethanol Injection-PEI)

16 Heat-Radio-frequency ablation (RFA)

17 Other (ultrasound, acetic acid)

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

20 Wedge or segmental resection, NOS

21 Wedge resection

22 Segmental resection, NOS

23 One

24 Two

25 Three

26 Segmental resection AND local tumor destruction

30 Lobectomy, NOS

36 Right lobectomy

37 Left lobectomy

38 Lobectomy AND local tumor destruction

50 Extended lobectomy, NOS (extended: resection of a single lobe plus a segment of another lobe)

51 Right lobectomy

52 Left lobectomy

59 Extended lobectomy AND local tumor destruction

60 Hepatectomy, NOS

61 Total hepatectomy and transplant

65 Excision of a bile duct (for an intra-hepatic bile duct primary only)

66 Excision of a bile duct PLUS partial hepatectomy

75 Bile duct and hepatectomy WITH transplant

Specimen sent to pathology from surgical events 20-75.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

PANCREAS
C25.0–C25.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 25 Local excision of tumor, NOS
- 30 Partial pancreatectomy, NOS; example: distal
- 35 Local or partial pancreatectomy and duodenectomy
 - 36 WITHOUT distal/partial gastrectomy
 - 37 WITH partial gastrectomy (Whipple)
- 40 Total pancreatectomy
- 60 Total pancreatectomy and subtotal gastrectomy or duodenectomy
- 70 Extended pancreatoduodenectomy
- 80 Pancreatectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

LARYNX
C32.0–C32.9

((Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

15 Stripping

No specimen sent to pathology from surgical events 10–15.

20 Local tumor excision, NOS

26 Polypectomy

27 Excisional biopsy

Any combination of 20 or 26–27 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

25 Laser excision

28 Stripping

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

31 Vertical laryngectomy

32 Anterior commissure laryngectomy

33 Supraglottic laryngectomy

40 Total or radical laryngectomy, NOS

41 Total laryngectomy ONLY

42 Radical laryngectomy ONLY

50 Pharyngolaryngectomy

80 Laryngectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

LUNG
C34.0–C34.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

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

15 Local tumor destruction, NOS

12 Laser ablation or cryosurgery

13 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

No specimen sent to pathology from surgical events 12–13 and 15.

20 Excision or resection of less than one lobe, NOS

23 Excision, NOS

24 Laser excision

25 Bronchial sleeve resection ONLY

21 Wedge resection

22 Segmental resection, including lingulectomy

30 Resection of lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)

33 Lobectomy WITH mediastinal lymph node dissection

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

45 Lobe or bilobectomy extended, NOS

46 WITH chest wall

47 WITH pericardium

48 WITH diaphragm

55 Pneumonectomy, NOS

56 WITH mediastinal lymph node dissection (radical pneumonectomy)

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

65 Extended pneumonectomy

66 Extended pneumonectomy plus pleura or diaphragm

70 Extended radical pneumonectomy

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

80 Resection of lung, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

**HEMATOPOIETIC/RETICULOENDOTHELIAL/
IMMUNOPROLIFERATIVE/MYELOPROLIFERATIVE DISEASE
C42.0, C42.1, C42.3, C42.4 (with any histology)**

or

M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992 (with any site)

Code

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

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

BONES, JOINTS AND ARTICULAR CARTILAGE C40.0–C41.9
PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM C47.0–C47.9
CONNECTIVE, SUBCUTANEOUS AND OTHER SOFT TISSUES C49.0–C49.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

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

15 Local tumor destruction

No specimen sent to pathology from surgical event 15.

25 Local excision

26 Partial resection

Specimen sent to pathology from surgical events 25–26.

30 Radical excision or resection of lesion WITH limb salvage

40 Amputation of limb

41 Partial amputation of limb

42 Total amputation of limb

50 Major amputation, NOS

51 Forequarter, including scapula

52 Hindquarter, including ilium/hip bone

53 Hemipelvectomy, NOS

54 Internal hemipelvectomy

Specimen sent to pathology from surgical events 25–54.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SPLEEN
Spleen C42.2

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

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

21 Partial splenectomy

22 Total splenectomy

80 Splenectomy, NOS

Specimen sent to pathology from surgical events 21–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SKIN
C44.0–C44.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser ablation

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

20 Local tumor excision, NOS

26 Polypectomy

27 Excisional biopsy

Any combination of 20 or 26–27 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

25 Laser excision

30 Biopsy of primary tumor followed by a gross excision of the lesion (does not have to be done under the same anesthesia)

31 Shave biopsy followed by a gross excision of the lesion

32 Punch biopsy followed by a gross excision of the lesion

33 Incisional biopsy followed by a gross excision of the lesion

34 Mohs surgery, NOS

35 Mohs with 1-cm margin or less

36 Mohs with more than 1-cm margin

45 Wide excision or reexcision of lesion or minor (local) amputation with margins more than 1 cm, NOS. Margins **MUST** be microscopically negative.

46 WITH margins more than 1 cm and less than or equal to 2 cm

47 WITH margins greater than 2 cm

If the excision does not have microscopically negative margins greater than 1 cm, use the appropriate code, 20–36.

60 Major amputation

Specimen sent to pathology from surgical events 20–60.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

**BREAST
C50.0–C50.9**

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction, NOS

No specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

20 Partial mastectomy, NOS; less than total mastectomy, NOS

21 Partial mastectomy WITH nipple resection

22 Lumpectomy or excisional biopsy

23 Re-excision of the biopsy site for gross or microscopic residual disease

24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

Procedures coded 20–24 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.

30 Subcutaneous mastectomy

A subcutaneous mastectomy, also called a nipple sparing mastectomy, is the removal of breast tissue without the nipple and areolar complex or overlying skin. It is performed to facilitate immediate breast reconstruction. Cases coded 30 may be considered to have undergone breast reconstruction.

40 Total (simple) mastectomy

41 WITHOUT removal of uninvolved contralateral breast

43 Reconstruction NOS

44 Tissue

45 Implant

46 Combined (Tissue and Implant)

42 WITH removal of uninvolved contralateral breast

47 Reconstruction NOS

48 Tissue

49 Implant

75 Combined (Tissue and Implant)

A total (simple) mastectomy removes all breast tissue, the nipple and areolar complex. An axillary dissection is not done.

For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294) or *Surgical Procedure/Other Site at This Facility* (NAACCR Item #674).

If contralateral breast reveals a second primary, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

Reconstruction that is planned as part of first course treatment is coded 43-49 or 75, whether it is done at the time of mastectomy or later.

- 50 Modified radical mastectomy
 - 51 WITHOUT removal of uninvolved contralateral breast
 - 53 Reconstruction, NOS
 - 54 Tissue
 - 55 Implant
 - 56 Combined (Tissue and Implant)
 - 52 WITH removal of uninvolved contralateral breast
 - 57 Reconstruction, NOS
 - 58 Tissue
 - 59 Implant
 - 63 Combined (Tissue and Implant)

Removal of all breast tissue, the nipple, the areolar complex and variable amounts of breast skin in continuity with the axilla. The specimen may or may not include a portion of the pectoralis major muscle.

If contralateral breast reveals a second primary, it is abstracted separately. The surgical procedure is coded 51 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site (NAACCR Item #1294)* or *Surgical Procedure/Other Site at This Facility (NAACCR Item #674)*.

- 60 Radical mastectomy, NOS
 - 61 WITHOUT removal of uninvolved contralateral breast
 - 64 Reconstruction, NOS
 - 65 Tissue
 - 66 Implant
 - 67 Combined (Tissue and Implant)
 - 62 WITH removal of uninvolved contralateral breast
 - 68 Reconstruction, NOS
 - 69 Tissue
 - 73 Implant
 - 74 Combined (Tissue and Implant)

- 70 Extended radical mastectomy
 - 71 WITHOUT removal of uninvolved contralateral breast
 - 72 WITH removal of uninvolved contralateral breast

80 Mastectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

CERVIX UTERI

C53.0–C53.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

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

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

15 Loop Electrocautery Excision Procedure (LEEP)

16 Laser ablation

17 Thermal ablation

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

20 Local tumor excision, NOS

26 Excisional biopsy, NOS

27 Cone biopsy

24 Cone biopsy WITH gross excision of lesion

29 Trachelectomy; removal of cervical stump; cervicectomy

Any combination of 20, 24, 26, 27 or 29 WITH

21 Electrocautery

22 Cryosurgery

23 Laser ablation or excision

25 Dilatation and curettage; endocervical curettage (for in-situ only)

28 Loop electrocautery excision procedure (LEEP)

30 Total hysterectomy (simple, pan-) WITHOUT removal of tubes and ovaries

Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

40 Total hysterectomy (simple, pan-) WITH removal of tubes and/or ovary

Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

50 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy

51 Modified radical hysterectomy

52 Extended hysterectomy

53 Radical hysterectomy; Wertheim procedure

54 Extended radical hysterectomy

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

61 WITHOUT removal of tubes and ovaries

62 WITH removal of tubes and ovaries

70 Pelvic exenteration

71 Anterior exenteration

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

72 Posterior exenteration

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

73 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes.

74 Extended exenteration

Includes pelvic blood vessels or bony pelvis.

Specimen sent to pathology from surgical events 20-74.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

CORPUS UTERI

C54.0–C55.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

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

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

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

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

15 Loop Electocautery Excision Procedure (LEEP)

16 Thermal ablation

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

20 Local tumor excision, NOS; simple excision, NOS

24 Excisional biopsy

25 Polypectomy

26 Myomectomy

Any combination of 20 or 24–26 WITH

21 Electrocautery

22 Cryosurgery

23 Laser ablation or excision

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

31 WITHOUT tube(s) and ovary(ies)

32 WITH tube(s) and ovary(ies)

40 Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary(ies)

Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

50 Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary(ies)

Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

60 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy

61 Modified radical hysterectomy

62 Extended hysterectomy

63 Radical hysterectomy; Wertheim procedure

64 Extended radical hysterectomy

65 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies)

66 WITHOUT removal of tube(s) and ovary(ies)

67 WITH removal of tube(s) and ovary(ies)

75 Pelvic exenteration

76 Anterior exenteration

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

77 Posterior exenteration

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

78 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes.

79 Extended exenteration

Includes pelvic blood vessels or bony pelvis.

Specimen sent to pathology from surgical events 20–79.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

**OVARY
C56.9**

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

17 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 17.

25 Total removal of tumor or (single) ovary, NOS

26 Resection of ovary (wedge, subtotal or partial) ONLY, NOS; unknown if hysterectomy done

27 WITHOUT hysterectomy

28 WITH hysterectomy

Specimen sent to pathology from surgical events 25–28.

35 Unilateral (salpingo-) oophorectomy; unknown if hysterectomy done

36 WITHOUT hysterectomy

37 WITH hysterectomy

50 Bilateral (salpingo-) oophorectomy; unknown if hysterectomy done

51 WITHOUT hysterectomy

52 WITH hysterectomy

55 Unilateral or bilateral (salpingo-) oophorectomy WITH OMENTECTOMY, NOS; partial or total; unknown if hysterectomy done

56 WITHOUT hysterectomy

57 WITH hysterectomy

60 Debulking; cytoreductive surgery, NOS

61 WITH colon (including appendix) and/or small intestine resection (not incidental)

62 WITH partial resection of urinary tract (not incidental)

63 Combination of 61 and 62

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

70 Pelvic exenteration, NOS

71 Anterior exenteration

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

72 Posterior exenteration

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

73 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes.

74 Extended exenteration

Includes pelvic blood vessels or bony pelvis.

80 (Salpingo-)oophorectomy, NOS

Specimen sent to pathology from surgical events 25-80

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

PROSTATE

C61.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item *Hematologic Transplant and Endocrine Procedures* (NAACCR Item #3250).

Codes

00 None; no surgery of primary site; autopsy ONLY

18 Local tumor destruction or excision, NOS

19 Transurethral resection (TURP), NOS

Unknown whether a specimen was sent to pathology for surgical events coded 18 or 19 (principally for cases diagnosed prior to January 1, 2003).

10 Local tumor destruction, NOS

14 Cryoprostatectomy

15 Laser ablation

16 Hyperthermia

17 Other method of local tumor destruction

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

20 Local tumor excision, NOS

21 Transurethral resection (TURP), NOS

22 TURP—cancer is incidental finding during surgery for benign disease

23 TURP—patient has suspected/known cancer

Any combination of 20–23 WITH

24 Cryosurgery

25 Laser

26 Hyperthermia

30 Subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact

50 Radical prostatectomy, NOS; total prostatectomy, NOS

Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck.

70 Prostatectomy WITH resection in continuity with other organs; pelvic exenteration

Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to, cystoprostatectomy, radical cystectomy and prostatectomy.

80 Prostatectomy, NOS

Specimen sent to pathology from surgical events 28–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

TESTIS
C62.0–C62.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

12 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 12.

20 Local or partial excision of testicle

30 Excision of testicle WITHOUT cord

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

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

Specimen sent to pathology from surgical event 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

KIDNEY, RENAL PELVIS AND URETER
Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-99922)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

15 Thermal ablation

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

20 Local tumor excision, NOS

26 Polypectomy

27 Excisional biopsy

Any combination of 20 or 26–27 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

25 Laser excision

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

Procedures coded 30 include, but are not limited to:

Segmental resection

Wedge resection

40 Complete/total/simple nephrectomy—for kidney parenchyma

Nephroureterectomy

Includes bladder cuff for renal pelvis or ureter.

50 Radical nephrectomy

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

70 Any nephrectomy (simple, subtotal, complete, partial, simple, total, radical) in continuity with the resection of other organ(s) (colon, bladder)

The other organs, such as colon or bladder, may be partially or totally removed.

80 Nephrectomy, NOS

Ureterectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

**BLADDER
C67.0–C67.9**

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

15 Intravesical therapy

16 Bacillus Calmette-Guerin (BCG) or other immunotherapy

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

20 Local tumor excision, NOS

26 Polypectomy

27 Excisional biopsy

Combination of 20 or 26–27 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

25 Laser excision

30 Partial cystectomy

50 Simple/total/complete cystectomy

60 Radical cystectomy with reconstruction

61 Radical cystectomy PLUS ileal conduit

62 Radical cystectomy PLUS continent reservoir or pouch, NOS

63 Radical cystectomy PLUS abdominal pouch (cutaneous)

64 Radical cystectomy PLUS in situ pouch (orthotopic)

When the procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code 60-64)

70 Pelvic exenteration, NOS

71 Radical cystectomy including anterior exenteration

For females, includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra. For males, includes removal of the prostate. When a procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code 60-64).

72 Posterior exenteration

For females, also includes removal of vagina, rectum and anus. For males, also includes prostate, rectum and anus.

73 Total exenteration

Includes all tissue and organs removed for an anterior and posterior exenteration.

74 Extended exenteration

Includes pelvic blood vessels or bony pelvis.

80 Cystectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

BRAIN
Meninges C70.0–C70.9, Brain C71.0–C71.9,
Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System C72.0–C72.9
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Do not code laminectomies for spinal cord primaries.

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Tumor destruction, NOS

No specimen sent to pathology from surgical event 10.

Do not record stereotactic radiosurgery (SRS), Gamma knife, Cyber knife, or Linac radiosurgery as surgical tumor destruction. All of these modalities are recorded in the radiation treatment fields.

20 Local excision of tumor, lesion or mass; excisional biopsy

21 Subtotal resection of tumor, lesion or mass in brain

22 Resection of tumor of spinal cord or nerve

30 Radical, total gross resection of tumor, lesion or mass in brain

40 Partial resection

55 Gross total resection of lobe of brain (lobectomy)

Codes 30 - 55 are not applicable for spinal cord or spinal nerve primary sites.

Specimen sent to pathology from surgical events 20-55.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

THYROID GLAND

C73.9

(Except for M9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

13 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 13.

25 Removal of less than a lobe, NOS

26 Local surgical excision

27 Removal of a partial lobe ONLY

20 Lobectomy and/or isthmectomy

21 Lobectomy ONLY

22 Isthmectomy ONLY

23 Lobectomy WITH isthmus

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

40 Subtotal or near total thyroidectomy

50 Total thyroidectomy

80 Thyroidectomy, NOS

Specimen sent to pathology from surgical events 25–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

LYMPH NODES

C77.0–C77.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

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

15 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 15.

25 Local tumor excision, NOS

Less than a full chain, includes an excisional biopsy of a single lymph node.

30 Lymph node dissection, NOS

31 One chain

32 Two or more chains

40 Lymph node dissection, NOS PLUS splenectomy

41 One chain

42 Two or more chains

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

51 One chain

52 Two or more chains

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

61 One chain

62 Two or more chains

Specimen sent to pathology from surgical event 25-62.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

ALL OTHER SITES

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

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

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

20 Local tumor excision, NOS

26 Polypectomy

27 Excisional biopsy

Any combination of 20 or 26–27 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

25 Laser excision

30 Simple/partial surgical removal of primary site

40 Total surgical removal of primary site; enucleation

41 Total enucleation (for eye surgery only)

50 Surgery stated to be “debulking”

60 Radical surgery

Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs.

Specimen sent to pathology from surgical events 20–60.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

**UNKNOWN AND ILL-DEFINED PRIMARY SITES
C76.0–C76.8, C80.9**

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code

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

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

APPENDIX 8

**North American Association of Central Cancer Registries (NAACCR)
*Standards for Cancer Registries, Volume II: Data Standards and Data
Dictionary,
Twelfth Edition, Version 12***

Appendix G: Recommended Abbreviations for Abstractors

APPENDIX G

RECOMMENDED ABBREVIATIONS FOR ABSTRACTORS

The use of abbreviations in cancer abstraction is becoming more commonplace as the demands on abstractors increase. Abbreviations often are used by cancer abstractors to shorten the written narratives entered into text fields to facilitate the electronic storage and transmission of the information. However, abbreviations can generate confusion, because abbreviations may vary among different institutions and even between different specialties within the same institution. To be useful, an abbreviation must be clearly understood by any individual who encounters it. Consequently, the use of abbreviations is a useful abstracting practice only if universally recognized and understood abbreviations are used.

The NAACCR Recommended Abbreviations Listings were developed for utilization by cancer report abstractors and the agencies to which they submit their data. These lists were compiled to reduce some of the confusion that can result from the use of common and not-so-common abbreviations when abstracting reports of cancer from the medical record. Although the lists may shed some light on abbreviations used in the medical record, please note that these lists are intended to be used as a primary reference by the cancer abstractor, to help abstract necessary information into a limited number of text fields for storage and transmission of cancer information.

The NAACCR Recommended Abbreviations Listings consist of two main lists of almost 500 word/terms and their recommended abbreviations/symbols, as well as a special table delineating context-sensitive abbreviations. The first main listing is ordered by word/term to enable the look-up of a recommended abbreviation for a particular word or term, and the second main listing is ordered by abbreviation/symbol to enable the look-up of the word or term for a particular abbreviation or symbol. The context-sensitive abbreviations list consists of a subset of the abbreviations from the main lists where a different context for the same abbreviation conveys a different meaning (for example, CA may mean calcium or carcinoma/ML may mean milliliter or middle lobe). For these context-sensitive abbreviations, the meaning of the abbreviation should be readily apparent from the context in which it is used.

The listings were compiled from abbreviation lists from SEER Book 3, the NAACCR Pathology Committee, the Veterans Administration, Dr. Jay Piccirillo's comorbid conditions training materials, the Florida Cancer Data System, and the California Cancer Registry. Terms included in the lists are limited to those that are commonly utilized when abstracting cancer information. The listings are not exhaustive, but many of the most commonly used terms were included. Abbreviations for chemotherapy drugs and/or regimens are not included. Please note that although abbreviations are presented in uppercase, either upper- or lowercase may be utilized when entering abbreviations within abstraction software. When abstracting into text fields, the use of abbreviations should be limited to those that appear on these lists whenever practical. Abbreviations and symbols should be used carefully. Any questions or suggestions for new/modified abbreviations may be e-mailed to either of the current Chairpersons of the NAACCR Registry Operations Committee.

**NAACCR RECOMMENDED ABBREVIATION LIST
ORDERED BY WORD/TERM(S)**

WORD/TERM(S)	ABBREVIATION/SYM
Abdomen (abdominal)	ABD
Abdominal perineal	AP
Abnormal	ABN
Above	^
Above knee (amputation)	AK(A)
Absent/Absence	ABS
Abstract/Abstracted	ABST
Achilles tendon reflex	ATR
Acid phosphatase	ACID PHOS
Acquired Immune Deficiency Syndrome	AIDS
Activities of daily living	ADL
Acute granulocytic leukemia	AGL
Acute lymphocytic leukemia	ALL
Acute myelogenous leukemia	AML
Acute myocardial infarction	AMI
Acute Respiratory Distress (Disease) Syndrome	ARDS
Acute tubular necrosis	ATN
Acute renal failure	ARF
Adenocarcinoma	ADENOCA
Adenosine triphosphate	ATP
Adjacent	ADJ
Adult-onset Diabetes Mellitus	AODM
Admission/Admit	ADM
Adrenal cortical hormone	ACH
Adrenal cortex	AC
Adrenocorticotrophic hormone	ACTH
Affirmative	AFF
Against medical advice	AMA
AIDS-related condition (complex)	ARC
AIDS-related disease	ARD
Air contrast barium enema	ACBE
Albumin	ALB
Alcohol	ETOH
Alkaline phosphatase	ALK PHOS
Alpha-fetoprotein	AFP
Also known as	AKA
Ambulatory	AMB
Amount	AMT
Amputation	AMP
Amyotrophic lateral sclerosis	ALS
Anal intraepithelial neoplasia, grade III	AIN III
Anaplastic	ANAP

WORD/TERM(S)	ABBREVIATION/SYM
And	&
Angiography/Angiogram	ANGIO
Anterior	ANT
Anteroposterior	AP
Antidiuretic hormone	ADH
Antigen	AG
Aortic stenosis	A-STEN
Appendix	APP
Apparently	APPL'Y
Approximately	APPROX
Arrhythmia	ARRHY
Arterial blood gases	ABG
Arteriosclerotic cardiovascular disease	ASCVD
Arteriosclerotic heart disease	ASHD
Arteriosclerotic Peripheral Vascular Disease	ASPVD
Arteriosclerosis/Arteriosclerotic	AS
Arteriovenous	AV
Arteriovenous malformation	AVM
Artery (ial)	ART
Ascending colon	A-COLON
Aspiration	ASP
Aspirin, Acetylsalicylic acid	ASA
As soon as possible	ASAP
At	@
Atrial fibrillation	A FIB
Atrial flutter	A FLUTTER
Atrial stenosis/insufficiency/incompetence	AI
Atrial premature complexes	APC
Auscultation & percussion	A&P
Autonomic nervous system	ANS
Autopsy	AUT
Autoimmune hemolytic anemia	AIHA
Average	AVG
Axilla(ry)	AX
Bacillus Calmette-Guerin	BCG
Barium	BA
Barium enema	BE
Bartholin's, Urethral & Skene's	BUS
Basal cell carcinoma	BCC
Before noon	AM
Below knee (amputation)	BK(A)
Benign prostatic hypertrophy/hyperplasia	BPH
Bilateral	BIL
Bilateral salpingo-oophorectomy	BSO
Bile duct	BD

WORD/TERM(S)	ABBREVIATION/SYM
Biological response modifier	BRM
Biopsy	BX
Bipolar affective disorder	BAD
Black female	B/F
Black male	B/M
Bladder tumor	BT
Blood pressure	BP
Blood urea nitrogen	BUN
Blood volume	BV
Bone marrow	BM
Bone marrow transplant	BMT
Bowel movement	BM
Brother	BRO
Calcium	CA
Capsule (s)	CAP(S)
Carcinoembryonic antigen	CEA
Carcinoma	CA
Carcinoma <i>in situ</i>	CIS
Cardiovascular disease	CVD
CAT/CT scan/Computerized axial tomography	CT
Centimeter	CM
Central nervous system	CNS
Cerebrospinal fluid	CSF
Cerebrovascular accident	CVA
Cervical intraepithelial neoplasia	CIN
Cervical intraepithelial neoplasia, grade III	CIN III
Cervical vertebrae	C1-C7
Cervical spine	C-SPINE
Change	CHG
Chemotherapy	CHEMO
Chest X-ray	CXR
Chronic	CHR
Chronic granulocytic leukemia	CGL
Chronic lymphocytic leukemia	CLL
Chronic myeloid (myelocytic) leukemia	CML
Chronic obstructive lung disease	COLD
Chronic obstructive pulmonary disease	COPD
Chronic renal failure	CRF
Chronic ulcerative colitis	CUC
Cigarettes	CIG
Clear	CLR
Cobalt 60	CO60
Collaborative stage	CS
Colon, Ascending	A-COLON
Colon, Descending	D-COLON

WORD/TERM(S)	ABBREVIATION/SYM
Colon, Sigmoid	SIG COLON
Colon, Transverse	TRANS-COLON
Colony-stimulating factor	C-SF
Complaint (-ning) of	C/O
Complete blood count	CBC
Congenital heart disease	CHD
Congestive heart failure	CHF
Consistent with	C/W
Continue/continuous	CONT
Contralateral	CONTRA
Coronary artery bypass graft	CABG
Coronary artery disease	CAD
Coronary care unit	CCU
Cubic centimeter	CC
Cystoscopy	CYSTO
Cytology	CYTO
Cystic fibrosis	CF
Date of birth	DOB
Date of death	DOD
Dead on arrival	DOA
Decrease(d)	DECR
Deep tendon reflex	DTR
Deep vein thrombosis	DVT
Deoxyribonucleic acid	DNA
Descending colon	D-COLON
Dermatology	DERM
Diabetes mellitus	DM
Diagnosis	DX
Diameter	DIAM
Diethylstilbestrol	DES
Differentiated/differential	DIFF
Digital rectal examination	DRE
Dilatation and curettage	D&C
Discharge	DISCH
Discontinue(d)	DC
Disease	DZ
Disseminated intravascular coagulopathy	DIC
Ductal carcinoma <i>in situ</i>	DCIS
Dyspnea on exertion	DOE
Ears, nose, and throat	ENT
Electrocardiogram	ECG/EKG
Electroencephalogram	EEG
Electromyogram	EMG
Emergency room	ER

WORD/TERM(S)	ABBREVIATION/SYM
Endoscopic retrograde cholangiopancreatography	ERCP
End stage renal disease	ESRD
Enlarged	ENLGD
Equal(s)	=
Esophagogastro-duodenoscopy	EGD
Estrogen receptor (assay)	ER, ERA
Evaluation	EVAL
Every	Q
Every day	QD
Examination	EXAM
Excision/excised	EXC(D)
Expired	EXP
Exploratory	EXPL
Exploratory laparotomy	EXPL LAP
Extend/extension	EXT
Fever of unknown origin	FUO
Fine needle aspiration	FNA
Fine needle aspiration biopsy	FNAB
Floor of mouth	FOM
Fluid	FL
Fluoroscopy	FLURO
Follow-up	FU
For example	E.G.
Fracture	FX
Frequent/Frequency	FREQ
Frozen section	FS
Full thickness skin graft	FTSG
Gallbladder	GB
Gastroesophageal	GE
Gastroesophageal reflux disease	GERD
Gastrointestinal	GI
General/Generalized	GEN
Genitourinary	GU
Grade	GR
Greater/Greater than	>
Gynecology	GYN
Hematocrit	HCT
Hemoglobin	HGB
Hepatitis A (virus)	HAV
Hepatitis B (virus)	HBV
Hepatitis C (virus)	HCV
Hepatitis D (virus)	HDV
Hepatosplenomegaly	HSM

WORD/TERM(S)	ABBREVIATION/SYM
History	HX
History and physical	H&P
History of	H/O
Hormone	HORM
Hospital	HOSP
Hour/Hours	HR(S)
Human chorionic gonadotropin	HCG
Human Immunodeficiency Virus	HIV
Human Papilloma Virus	HPV
Human T-Lymphotropic Virus, (Type III)	HTLV
Hypertension	HTN
Hypertensive cardiovascular disease	HCVD
Hypertensive vascular disease	HVD
Hysterectomy	HYST
Idiopathic hypertrophic subaortic stenosis	IHSS
Idiopathic thrombocytopenia	ITP
Immunoglobulin	IG
Immunohistochemical	IHC
Impression	IMP
Incision & drainage	I&D
Includes/Including	INCL
Increase(d)	INCR
Inferior	INF
Inferior vena cava	IVC
Infiltrating	INFILT
Inflammatory bowel disease	IBD
Inpatient	IP
Insulin-dependent diabetes mellitus	IDDM
Intensive care unit	ICU
Intercostal margin	ICM
Intercostal space	ICS
Intermittent positive pressure breathing	IPPB
Internal	INT
Interstitial lung disease	ILD
Intramuscular	IM
Intrathecal	IT
Intravenous	IV
Intravenous cholangiogram	IVCA
Intravenous pyelogram	IVP
Invade(s)/invading/invasion	INV
Involve(s)/involvement/involving	INVL
Ipsilateral	IPSI
Irregular	IRREG
Jugular venous distention	JVD

WORD/TERM(S)	ABBREVIATION/SYM
Juvenile rheumatic arthritis	JRA
Kaposi sarcoma	KS
Kidneys, ureters, bladder	KUB
Kilogram	KG
Kilovolt	KV
laboratory	LAB
Lactic dehydrogenase	LDH
Laparotomy	LAP
Large	LRG
Last menstrual period	LMP
Lateral	LAT
Left	LT
Left bundle branch block	LBBB
Left costal margin	LCM
Left lower extremity	LLE
Left lower lobe	LLL
Left lower quadrant	LLQ
Left salpingo-oophorectomy	LSO
Left upper extremity	LUE
Left upper lobe	LUL
Left upper quadrant	LUQ
Left upper outer quadrant	LUOQ
Less/Less than	<
Licensed practical nurse	LPN
Linear accelerator	LINAC
Liver/spleen scan	LS SCAN
Lower extremity	LE
Lower inner quadrant	LIQ
Lower outer quadrant	LOQ
Lumbar vertebra	L1-L5
Lumbar spine	L-SPINE
Lumbosacral	LS
Lymphadenopathy-associated virus	LAV
Lymph node(s)	LN(S)
Lymph node dissection	LND
Lupus erythematosus	LUP ERYTH
Macrophage colony-stimulating factor	M-CSF
Magnetic resonance imaging	MRI
Magnetic resonance cholangiopancreatography	MRCP
Main stem bronchus	MSB
Malignant	MALIG
Mandible/mandibular	MAND
Maximum	MAX

WORD/TERM(S)	ABBREVIATION/SYM
Medical center	MC
Medication	MED
Metastatic/Metastasis	METS
Methicillin Resistant Staphylococcus Aureus	MRSA
Microgram	MCG
Microscopic	MICRO
Middle lobe	ML
Millicurie (hours)	MC(H)
Milligram (hours)	MG(H)
Milliliter	ML
Millimeter	MM
Million electron volts	MEV
Minimum	MIN
Minus	-
Minute	MIN
Mitral valve prolapse	MVP
Mixed combined immunodeficiency	MCID
Mixed connective tissue disease	MCTD
Moderate (ly)	MOD
Moderately differentiated	MD, MOD DIFF
Modified radical mastectomy	MRM
More/More than	>
Multifocal arterial tachycardia	MAT
Multifocal premature ventricular contraction	MPVC
Multiple	MULT
Multiple sclerosis	MS
Multiple myeloma	MM
Myasthenia gravis	MG
Myocardial infarction	MI
Neck vein distention	NVD
Negative	NEG
Negative	-
Neoplasm	NEOPL
Neurology	NEURO
No evidence of disease	NED
No significant findings	NSF
Non-Hodgkins lymphoma	NHL
Normal	NL
Non small cell carcinoma	NSCCA
Not applicable	NA
Not otherwise specified	NOS
Not recorded	NR
Number	#
Nursing home	NH

WORD/TERM(S)	ABBREVIATION/SYM
Obstetrics	OB
Obstructed (-ing, -ion)	OBST
Operating room	OR
Operative report	OP RPT
Organic brain syndrome	OBS
Orthopedics	ORTHO
Otology	OTO
Ounce	OZ
Outpatient	OP
Packs per day	PPD
Palpated (-able)	PALP
Papanicolaou smear	PAP
Papillary	PAP
Past/personal (medical) history	PMH
Pathology	PATH
Patient	PT
Pediatrics	PEDS
Pelvic inflammatory disease	PID
Peptic ulcer disease	PUD
Percutaneous	PERC
Percutaneous transhepatic cholecystogram	PTC
Peripheral vascular disease	PVD
Prescription	RX
Primary medical physician	PMP
Phosphorus 32	P32
Physical examination	PE
Physiotherapy/Physical therapy	PT
Platelets	PLT
Plus	+
Poorly differentiated	PD, POOR DIFF
Positive	POS
Positive	+
Positron emission tomography	PET
Possible	POSS
Posterior	POST
Postoperative (-ly)	POST OP
Pound(s)	LB(S)
Pound(s)	#
Premature atrial contraction	PAC
Preoperative (-ly)	PRE OP
Previous	PREV
Prior to admission	PTA
Probable (-ly)	PROB
Proctoscopy	PROCTO
Progesterone receptor (assay)	PR, PRA

WORD/TERM(S)	ABBREVIATION/SYM
Prostatic intraepithelial neoplasia, grade III	PIN III
Prostatic specific antigen	PSA
Pulmonary	PULM
Quadrant	QUAD
Radiation absorbed dose	RAD
Radiation therapy	RT
Radioimmunoassay	RIA
Received	REC'D
Red blood cells (count)	RBC
Regarding	RE
Regional medical center	RMC
Regular	REG
Regular sinus rhythm	RSR
Resection (ed)	RESEC
Review of outside films	ROF
Review of outside slides	ROS
Rheumatoid arthritis	RA
Rheumatic heart disease	RHD
Right	RT
Right bundle branch block	RBBB
Right costal margin	RCM
Right inner quadrant	RIQ
Right lower extremity	RLE
Right lower lobe	RLL
Right lower quadrant	RLQ
Right middle lobe	RML
Right outer quadrant	ROQ
Right salpingo-oophorectomy	RSO
Right upper extremity	RUE
Right upper lobe	RUL
Right upper quadrant	RUQ
Rule out	R/O
Sacral spine	S-SPINE
Sacral vertebra	S1-S5
Salpingo-oophorectomy	SO
Satisfactory	SATIS
Serum glutamic oxaloacetic transaminase	SGOT
Serum glutamic pyruvic transaminase	SGPT
Severe combined immunodeficiency syndrome	SCID
Short(ness) of breath	SOB
Sick sinus syndrome	SSS
Sigmoid colon	SIG COLON
Small	SM

WORD/TERM(S)	ABBREVIATION/SYM
Small bowel	SB
Specimen	SPEC
Spine, Cervical	C-SPINE
Spine, Lumbar	L-SPINE
Spine, Sacral	S-SPINE
Spine, Thoracic	T-SPINE
Split thickness skin graft	STSG
Squamous	SQ
Squamous cell carcinoma	SCC
Status post	S/P
Subcutaneous	SUBCU
Summary stage	SS
Superior vena cava	SVC
Surgery/Surgical	SURG
Suspicious/suspected	SUSP
Symptoms	SX
Syndrome of inappropriate ADH	SIADH
Systemic lupus erythematosus	SLE
Thoracic spine	T-SPINE
Thromboticthrombocytopenia purpura	TTP
Times	X
Total abdominal hysterectomy	TAH
Total abdominal hysterectomy- bilateral	TAH-BSO
Total vaginal hysterectomy	TVH
Transient ischemic attack	TIA
Transitional cell carcinoma	TCC
Transurethral resection	TUR
Transurethral resection bladder	TURB
Transurethral resection prostate	TURP
Transverse colon	TRANS-COLON
Treatment	TX
True vocal cord	TVC
Tuberculosis	TB
Twice a day (daily)	BID
Ultrasound	US
Undifferentiated	UNDIFF
Unknown	UNK
Upper extremity	UE
Upper gastrointestinal (series)	UGI
Upper inner quadrant	UIQ
Upper outer quadrant	UOQ
Upper respiratory infection	URI
Urinary tract infection	UTI
Vagina/Vaginal	VAG

WORD/TERM(S)	ABBREVIATION/SYM
Vaginal hysterectomy	VAG HYST
Vaginal intraepithelial neoplasia (grade III)	VAIN III
Vulvar intraepithelial neoplasia (grade III)	VIN III
Well differentiated	WD, WELL DIFF
White blood cells (count)	WBC
White female	W/F
White male	W/M
With	W/
Within normal limits	WNL
Without	W/O
Wolff-Parkinson-White syndrome	WPW
Work-up	W/U
Xray	XR
Year	YR

**NAACCR RECOMMENDED ABBREVIATION LIST
ORDERED BY ABBREVIATION/SYMBOL**

ABBREVIATION/SYM	WORD/TERM(S)
^	above
@	at
&	and
<	less, less than
=	equals
>	greater than, more, more than
-	negative, minus
#	number, pound(s)
+	plus, positive
X	times
A-COLON	Ascending colon
A FIB	Atrial fibrillation
A FLUTTER	Atrial flutter
A-STEN	Aortic stenosis
A&P	Auscultation & percussion
ABD	Abdomen (abdominal)
ABG	Arterial blood gases
ABN	Abnormal
ABS	Absent/Absence
ABST	Abstract/Abstracted
AC	Adrenal cortex
ACBE	Air contrast barium enema
ACH	Adrenal cortical hormone
ACID PHOS	Acid phosphatase
ACTH	Adrenocorticotrophic hormone
ADENOCA	Adenocarcinoma
ADH	Antidiuretic hormone
ADJ	Adjacent
ADL	Activities of daily living
ADM	Admission/Admit
AFF	Affirmative
AFP	Alpha-fetoprotein
AG	Antigen
AGL	Acute granulocytic leukemia
AI	Atrial stenosis/insufficiency/incompetence
AIDS	Acquired Immune Deficiency Syndrome
AIHA	Autoimmune hemolytic anemia
AIN III	Anal intraepithelial neoplasia, grade III
AK(A)	Above knee (amputation)
AKA	Also known as

ABBREVIATION/SYM	WORD/TERM(S)
ALB	Albumin
ALK PHOS	Alkaline phosphatase
ALL	Acute lymphocytic leukemia
ALS	Amyotrophic lateral sclerosis
AM	Before noon
AMA	Against medical advice
AMB	Ambulatory
AMI	Acute myocardial infarction
AML	Acute myelogenous leukemia
AMP	Amputation
AMT	Amount
ANAP	Anaplastic
ANGIO	Angiography/Angiogram
ANS	Autonomic nervous system
ANT	Anterior
AODM	Adult-onset Diabetes Mellitus
AP	Abdominal perineal
AP	Anteroposterior
APC	Atrial premature complexes
APP	Appendix
APPLY	Apparently
APPROX	Approximately
ARC	AIDS-related condition (complex)
ARD	AIDS-related disease
ARDS	Acute Respiratory Distress (Disease)
ARF	Acute renal failure
ARRHY	Arrhythmia
ART	Artery (ial)
AS	Arteriosclerosis/Arteriosclerotic
ASA	Aspirin, Acetylsalicylic acid
ASAP	As soon as possible
ASCVD	Arteriosclerotic cardiovascular disease
ASHD	Arteriosclerotic heart disease
ASP	Aspiration
ASPVD	Arteriosclerotic Peripheral Vascular Disease
ATN	Acute tubular necrosis
ATP	Adenosine triphosphate
ATR	Achilles tendon reflex
AUT	Autopsy
AV	Arteriovenous
AVG	Average
AVM	Arteriovenous malformation
AX	Axilla(ry)

ABBREVIATION/SYM	WORD/TERM(S)
B/F	Black female
B/M	Black male
BA	Barium
BAD	Bipolar affective disorder
BCC	Basal cell carcinoma
BCG	Bacillus Calmette-Guerin
BD	Bile duct
BE	Barium enema
BID	Twice a day (daily)
BIL	Bilateral
BK(A)	Below knee (amputation)
BM	Bone marrow
BM	Bowel movement
BMT	Bone marrow transplant
BP	Blood pressure
BPH	Benign prostatic hypertrophy/hyperplasia
BRM	Biological response modifier
BRO	Brother
BSO	Bilateral salpingo-oophorectomy
BT	Bladder tumor
BUN	Blood urea nitrogen
BUS	Bartholin's, Urethral & Skene's
BV	Blood volume
BX	Biopsy
C/O	Complaint (-ning) of
C/W	Consistent with
C1-C7	Cervical vertebrae
CA	Calcium
CA	Carcinoma
CABG	Coronary artery bypass graft
CAD	Coronary artery disease
CAP(S)	Capsule (s)
CBC	Complete blood count
CC	Cubic centimeter
CCU	Coronary care unit
CEA	Carcinoembryonic antigen
CF	Cystic fibrosis
CGL	Chronic granulocytic leukemia
CHD	Congenital heart disease
CHEMO	Chemotherapy
CHF	Congestive heart failure
CHG	Change
CHR	Chronic

ABBREVIATION/SYM	WORD/TERM(S)
CIG	Cigarettes
CIN	Cervical intraepithelial neoplasia
CIN III	Cervical intraepithelial neoplasia, grade III
CIS	Carcinoma <i>in situ</i>
CLL	Chronic lymphocytic leukemia
CLR	Clear
CM	Centimeter
CML	Chronic myeloid (myelocytic) leukemia
CNS	Central nervous system
CO60	Cobalt 60
COLD	Chronic obstructive lung disease
CONT	Continue/continuous
CONTRA	Contralateral
COPD	Chronic obstructive pulmonary disease
CRF	Chronic renal failure
CS	Collaborative stage
CSF	Cerebrospinal fluid
C-SF	Colony stimulating factor
C-SPINE	Cervical spine
CT	CAT/CT scan/Computerized axial
CUC	Chronic ulcerative colitis
CVA	Cerebrovascular accident
CVD	Cardiovascular disease
CXR	Chest X-ray
CYSTO	Cystoscopy
CYTO	Cytology
D-COLON	Descending colon
D&C	Dilatation and curettage
DC	Discontinue(d)
DCIS	Ductal carcinoma <i>in situ</i>
DECR	Decrease(d)
DERM	Dermatology
DES	Diethylstilbestrol
DIAM	Diameter
DIC	Disseminated intravascular coagulopathy
DIFF	Differentiated/differential
DISCH	Discharge
DM	Diabetes mellitus
DNA	Deoxyribonucleic acid
DOA	Dead on arrival
DOB	Date of birth
DOD	Date of death
DOE	Dyspnea on exertion

ABBREVIATION/SYM	WORD/TERM(S)
DRE	Digital rectal examination
DTR	Deep tendon reflex
DVT	Deep vein thrombosis
DX	Diagnosis
DZ	Disease
E.G.	For example
ECG/EKG	Electrocardiogram
EEG	Electroencephalogram
EGD	Esophagogastro-duodenoscopy
EMG	Electromyogram
ENLGD	Enlarged
ENT	Ears, nose, and throat
ER	Emergency room
ER, ERA	Estrogen receptor (assay)
ERCP	Endoscopic retrograde
ESRD	End stage renal disease
ETOH	Alcohol
EVAL	Evaluation
EXAM	Examination
EXC(D)	Excision/excised
EXP	Expired
EXPL	Exploratory
EXPL LAP	Exploratory laparotomy
EXT	Extend/extension
FL	Fluid
FLURO	Fluoroscopy
FNA	Fine needle aspiration
FNAB	Fine needle aspiration biopsy
FOM	Floor of mouth
FREQ	Frequent/Frequency
FS	Frozen section
FTSG	Full thickness skin graft
FU	Follow-up
FUO	Fever of unknown origin
FX	Fracture
GB	Gallbladder
GE	Gastroesophageal
GEN	General/Generalized
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GR	Grade

ABBREVIATION/SYM	WORD/TERM(S)
GU	Genitourinary
GYN	Gynecology
H&P	History and physical
H/O	History of
HAV	Hepatitis A (virus)
HBV	Hepatitis B (virus)
HCG	Human chorionic gonadotropin
HCT	Hematocrit
HCV	Hepatitis C (virus)
HCVD	Hypertensive cardiovascular disease
HDV	Hepatitis D (virus)
HGB	Hemoglobin
HIV	Human Immunodeficiency Virus
HORM	Hormone
HOSP	Hospital
HPV	Human Papilloma Virus
HR(S)	Hour/Hours
HSM	Hepatosplenomegaly
HTLV	Human T-Lymphotropic Virus, (Type III)
HTN	Hypertension
HVD	Hypertensive vascular disease
HX	History
HYST	Hysterectomy
I&D	Incision & drainage
IBD	Inflammatory bowel disease
ICM	Intercostal margin
ICS	Intercostal space
ICU	Intensive care unit
IDDM	Insulin-dependent diabetes mellitus
IG	Immunoglobulin
IHC	Immunohistochemical
IHSS	Idiopathic hypertrophic subaortic stenosis
ILD	Interstitial lung disease
IM	Intramuscular
IMP	Impression
INCL	Includes/Including
INCR	Increase(d)
INF	Inferior
INFILT	Infiltrating
INT	Internal
INV	Invade(s)/invading/invasion
INVL	Involve(s)/involvement/involving

ABBREVIATION/SYM	WORD/TERM(S)
IP	Inpatient
IPPB	Intermittent positive pressure breathing
IPSI	Ipsilateral
IRREG	Irregular
IT	Intrathecal
ITP	Idiopathic thrombocytopenia
IV	Intravenous
IVC	Inferior vena cava
IVCA	Intravenous cholangiogram
IVP	Intravenous pyelogram
JRA	Juvenile rheumatic arthritis
JVD	Jugular venous distention
KG	Kilogram
KS	Kaposi sarcoma
KUB	Kidneys, ureters, bladder
KV	Kilovolt
L-SPINE	Lumbar spine
L1-L5	Lumbar vertebra
LAB	laboratory
LAP	Laparotomy
LAT	Lateral
LAV	Lymphadenopathy-associated virus
LB	Pound
LBBB	Left bundle branch block
LCM	Left costal margin
LDH	Lactic dehydrogenase
LE	Lower extremity
LINAC	Linear accelerator
LIQ	Lower inner quadrant
LLE	Left lower extremity
LLL	Left lower lobe
LLQ	Left lower quadrant
LMP	Last menstrual period
LN(S)	Lymph node(s)
LND	Lymph node dissection
LOQ	Lower outer quadrant
LPN	Licensed practical nurse
LRG	Large
LS	Lumbosacral
LS SCAN	Liver/spleen scan
LSO	Left salpingo-oophorectomy

ABBREVIATION/SYM	WORD/TERM(S)
LT	Left
LUE	Left upper extremity
LUL	Left upper lobe
LUOQ	Left upper outer quadrant
LUP ERYTH	Lupus erythematosus
LUQ	Left upper quadrant
M-CSF	Macrophage colony-stimulating factor
MALIG	Malignant
MAND	Mandible/mandibular
MAT	Multifocal arterial tachycardia
MAX	Maximum
MC	Medical center
MC(H)	Millicurie (hours)
MCG	Microgram
MCID	Mixed combined immunodeficiency
MCTD	Mixed connective tissue disease
MD	Moderately differentiated
MED	Medication
METS	Metastatic/Metastasis
MEV	Million electron volts
MG	Myasthenia gravis
MG(H)	Milligram (hours)
MI	Myocardial infarction
MICRO	Microscopic
MIN	Minimum
MIN	Minute
ML	Middle lobe
ML	Milliliter
MM	Millimeter
MM	Multiple myeloma
MOD	Moderate (ly)
MOD DIFF	Moderately differentiated
MPVC	Multifocal premature ventricular contraction
MRCP	Magnetic resonance
MRI	Magnetic resonance imaging
MRM	Modified radical mastectomy
MRSA	Methicillin Resistant StaphyloCoCcus Aureus
MS	Multiple sclerosis
MSB	Main stem bronchus
MULT	Multiple
MVP	Mitral valve prolapse
NA	Not applicable

ABBREVIATION/SYM	WORD/TERM(S)
NED	No evidence of disease
NEG	Negative
NEOPL	Neoplasm
NEURO	Neurology
NH	Nursing home
NHL	Non-Hodgkins lymphoma
NL	Normal
NOS	Not otherwise specified
NR	Not recorded
NSCCA	Non small cell carcinoma
NSF	No significant findings
NVD	Neck vein distention
OB	Obstetrics
OBS	Organic brain syndrome
OBST	Obstructed (-ing, -ion)
OP	Outpatient
OP RPT	Operative report
OR	Operating room
ORTHO	Orthopedics
OTO	Otology
OZ	Ounce
P32	Phosphorus 32
PAC	Premature atrial contraction
PALP	Palpated (-able)
PAP	Papanicolaou smear
PAP	Papillary
PATH	Pathology
PD	Poorly differentiated
PE	Physical examination
PEDS	Pediatrics
PERC	Percutaneous
PET	Positron emission tomography
PID	Pelvic inflammatory disease
PIN III	Prostatic intraepithelial neoplasia, grade III
PLT	Platelets
PMH	Past/personal (medical) history
PMP	Primary medical physician
POOR DIFF	Poorly differentiated
POS	Positive
POSS	Possible
POST	Posterior
POST OP	Postoperative (-ly)

ABBREVIATION/SYM	WORD/TERM(S)
PPD	Packs per day
PR, PRA	Progesterone receptor (assay)
PRE OP	Preoperative (-ly)
PREV	Previous
PROB	Probable (-ly)
PROCTO	Proctoscopy
PSA	Prostatic specific antigen
PT	Patient
PT	Physiotherapy/Physical therapy
PTA	Prior to admission
PTC	Percutaneous transhepatic cholecystogram
PUD	Peptic ulcer disease
PULM	Pulmonary
PVD	Peripheral vascular disease
Q	Every
QD	Every day
QUAD	Quadrant
R/O	Rule out
RA	Rheumatoid arthritis
RAD	Radiation absorbed dose
RBBB	Right bundle branch block
RBC	Red blood cells (count)
RCM	Right costal margin
RE	Regarding
REC'D	Received
REG	Regular
RESEC	Resection (ed)
RHD	Rheumatic heart disease
RIA	Radioimmunoassay
RIQ	Right inner quadrant
RLE	Right lower extremity
RLL	Right lower lobe
RLQ	Right lower quadrant
RMC	Regional medical center
RML	Right middle lobe
ROF	Review of outside films
ROQ	Right outer quadrant
ROS	Review of outside slides
RSO	Right salpingo-oophorectomy
RSR	Regular sinus rhythm
RT	Radiation therapy
RT	Right

ABBREVIATION/SYM	WORD/TERM(S)
RUE	Right upper extremity
RUL	Right upper lobe
RUQ	Right upper quadrant
RX	Prescription
S/P	Status post
S1-S5	Sacral vertebra
S-SPINE	Sacral spine
SATIS	Satisfactory
SB	Small bowel
SCC	Squamous cell carcinoma
SCID	Severe combined immunodeficiency
SGOT	Serum glutamic oxaloacetic transaminase
SGPT	Serum glutamic pyruvic transaminase
SIADH	Syndrome of inappropriate ADH
SIG COLON	Sigmoid colon
SLE	Systemic lupus erythematosus
SM	Small
SO	Salpingo-oophorectomy
SOB	Short(ness) of breath
SPEC	Specimen
SQ	Squamous
SS	Summary stage
SSS	Sick sinus syndrome
STSG	Split thickness skin graft
SUBCU	Subcutaneous
SURG	Surgery/Surgical
SUSP	Suspicious/suspected
SVC	Superior vena cava
SX	Symptoms
T-SPINE	Thoracic spine
TAH	Total abdominal hysterectomy
TAH-BSO	Total abdominal hysterectomy- bilateral
TB	Tuberculosis
TCC	Transitional cell carcinoma
TIA	Transient ischemic attack
TRANS-COLON	Transverse colon
TTP	Thromboticthrombocytopenia purpura
TUR	Transurethral resection
TURB	Transurethral resection bladder
TURP	Transurethral resection prostate
TVC	True vocal cord
TVH	Total vaginal hysterectomy

ABBREVIATION/SYM	WORD/TERM(S)
TX	Treatment
UE	Upper extremity
UGI	Upper gastrointestinal (series)
UIQ	Upper inner quadrant
UNDIFF	Undifferentiated
UNK	Unknown
UOQ	Upper outer quadrant
URI	Upper respiratory infection
US	Ultrasound
UTI	Urinary tract infection
VAG	Vagina/Vaginal
VAG HYST	Vaginal hysterectomy
VAIN III	Vaginal intraepithelial neoplasia (grade III)
VIN III	Vulvar intraepithelial neoplasia (grade III)
W/	With
W/F	White female
W/M	White male
W/O	Without
W/U	Work-up
WBC	White blood cells (count)
WD	Well differentiated
WELL DIFF	Well differentiated
WNL	Within normal limits
WPW	Wolff-Parkinson-White syndrome
XR	Xray
YR	Year

**NAACCR RECOMMENDED ABBREVIATION LIST
CONTEXT-SENSITIVE ABBREVIATIONS**

ABBREVIATION/SYM	WORD/TERM(S)
AP	Anteroposterior
AP	Abdominal perineal
BM	Bone marrow
BM	Bowel movement
CA	Calcium
CA	Carcinoma
MIN	Minimum
MIN	Minute
ML	Milliliter
ML	Middle lobe
MM	Millimeter
MM	Multiple myeloma
PAP	Papillary
PAP	Papanicolaou smear
PT	Patient
PT	Physiotherapy/Physical therapy
RT	Right
RT	Radiation therapy

APPENDIX 9

Removed by OCISS for Reporting Source Procedure Manual (Version 7)

