POLICY AND PROCEDURE MANUAL

FOR REPORTING FACILITIES – HOSPITALS

January 1, 2025

Effective For Cases Diagnosed January 1, 2025 and Later

Indiana State Cancer Registry
Indiana Department of Health
2 North Meridian Street, Section 6-B
Indianapolis, IN 46204-3010

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The Indiana State Cancer Registry Policy and Procedure Manual for Reporting Facilities was written by Jacqueline S. Harber, RHIA, CTR with assistance by Shelley Boltinghouse, RHIA, CTR and Stephen Nygaard of the Indiana State of Health and is in the public domain. It is based on the 1995 manual created by Martha Graves, RHIA, CTR (a former program director). The manual itself may be copied all, or in part.

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Indiana Cancer Registrars Association
Commission on Cancer, American College of Surgeons
North American Association of Central Cancer Registries
National Program of Cancer Registries (NPCR)/Center for Disease Control (CDC)
Surveillance, Epidemiology, and End Results Program-Data Management System (SEER*DMS)

INTRODUCTION

A. BACKGROUND

In 1985, the General Assembly of the State of Indiana passed Public Law 174-1985 establishing a cancer registry "for the purpose of recording all cases of malignant disease that occur in Indiana residents and compiling necessary and appropriate information concerning those cases...in order to conduct epidemiologic surveys of cancer and to apply appropriate preventive and control measures."[1]

An advisory committee was established to assist the Department of Health in creating such a registry. The committee developed the standards for establishing and maintaining the State Cancer Registry. They also helped develop a Policy and Procedure Manual and implemented training throughout the state. Hospitals, physicians, dentists, and medical laboratories began reporting January 1, 1987.

A 1988 amendment to the law allows the State Cancer Registry to release confidential information to another state's cancer registry if that state has entered into a reciprocal agreement with the Department of Health. The reciprocal agreement must state that information that identifies a patient will not be released to any other entity without the written consent of the patient.[2]

In 1991, IC 16-4-9-3 was amended to allow the state to enter into reciprocal agreements with other states in order to exchange data between cancer registries.

In a 1993 amendment, several laws were recodified. No substantial changes were made other than some minor wording changes, such as changing "State *Board* of Health" to "State *Department* of Health." The current law is IC 16-38-2.

This manual has been revised from the edition released in 1995 to reflect current laws and standards.

B. PURPOSE

The intent of this manual is to serve as a reference for hospitals reporting cases of malignant disease to the State Cancer Registry. The procedures set out in the manual have been developed in accordance with IC-38-2 and 410 IAC 21-1 (Appendix A).

C. DEFINITIONS

The terms *must, shall,* and *is required* are used throughout the manual to indicate what is mandatory and the only acceptable method under the law and rule. *Should* is used to reflect commonly accepted practices yet allows effective alternatives to be used. *May* is used to indicate an alternative that is acceptable, but not necessarily preferred.

D. REFERENCE MATERIALS

This Policy and Procedure Manual serves as a reference which is offered free of charge to reporting entities. For a complete list of required references and other resources, see Chapter 1.

[1] IC 16-4-9 (IC 16-38-2 since 1993)

[2] IC 16-4-9-6 (IC-38-2-6 since 1993)

E. CONSULTATION

Personnel of the State Cancer Registry are available by telephone and, in special circumstances, on site to provide consultation on all aspects of reporting. These include abstracting, organization and management, cancer registry software education, and updates on cancer data management at the both the state and national level. The Indiana Cancer Registrars Association has graciously offered to serve as a source for consultation, utilizing the expertise of experienced cancer registrars across the state.

F. OUTPUT

The rule for implementing statewide reporting mandates that the State provide each reporting facility a comprehensive annual report that outlines the trends of malignant disease in Indiana. Hospitals, physicians, dentists, medical laboratories, and other persons may request and be provided with individualized special reports as state resources permit.

G. QUALITY CONTROL

The State Cancer Registry monitors data quality through a variety of activities that are described in Chapter 7. The activities include careful monitoring of the number of cases submitted, visual review of abstracts for completeness and accuracy, and extensive electronic edits. Chapter 7 provides policies for clarification and modification of data. Continuing education and policy and procedure updates will focus on issues identified through quality control activities.

In summary, the State Cancer Registry serves as the state's repository of cancer data and an important resource offering a wide spectrum of services to the hospitals, physicians, dentists, and medical laboratories reporting to the State. As a tax supported service to health care professionals and the public, feedback regarding improvements in State Cancer Registry policies and services is welcomed.

CHAPTER 1: REFERENCES

A. REQUIRED REFERENCES

1. Indiana State Cancer Registry Policy and Procedure Manual.
   http://www.in.gov/isdh/24035.htm

2. International Classification of Diseases for Oncology, Third Edition (*ICD-O-3).* World health Organization, Geneva, Switzerland, 2000. ISBN: 9241545348. Effective for cases diagnosed January 1, 2001, forward.
   https://cancercenter.ai/icd_0_3_pathology/

   2024 *ICD-O-3.2* Coding Guidelines and Tables for New Codes and/or Terms (Implementation documents for implementation in 2022)
   https://www.naaccr.org/icdo3/

3. Solid Tumor Rules. National Cancer Institute, SEER Program.
   https://seer.cancer.gov/tools/solidtumor/

4. Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database.
   https://seer.cancer.gov/tools/heme/

5. Summary Stage 2018. National Cancer Institute, SEER Program'
   https://seer.cancer.gov/tools/ssm/

6. Grade Coding Instructions and Tables (V3.1, Oct 2023)

https://www.naaccr.org/wp-content/uploads/2023/10/Grade-Coding-Instructions-and-Tables-v3_printed.pdf?v=1700114453
Effective for cases diagnosed 1/1/2018 and forward

7. Site-Specific Data Items (SSDI): (V3.1)
https://apps.naaccr.org/ssdi/list/3.1
Effective for cases diagnosed 1/1/2018 and forward

8. SEER*Rx – Interactive Antineoplastic Drugs Database.
http://seer.cancer.gov/tools/seerrx/

B. ADDITIONAL RESOURCES

The following list identifies resources that may provide helpful information for use in the collection and abstraction of cancer data.

1. Standard for Oncology Registry Entry (STORE): STORE Manual Version 2025
    a. Historic Data Standards (previous versions of STORE Manual)
    b. CTR Guide to Coding Radiation Therapy Treatment is now included in STORE 2023+ Manual, Appendix R

2. AJCC Cancer Staging Manual, Eight Edition, American Joint Committee on Cancer (AJCC), V9: Cervix, Anus, Appendix, Brain & Spinal Cord (replaces specified sites within 8th edition on annual basis). 8th Edition and all version 9 chapters are available in Print, Amazon Kindle, or through the AJCC staging portal, visit AJCCStaging.org for more info.
    a. AJCC Cancer Staging Manual, V9
        i. Vulva Version 9 (for cases diagnosed 01/01/2024+)
        ii. Neuroendocrine Tumors of the Stomach Version 9 (for cases diagnosed 01/01/2024+)
        iii. Neuroendocrine Tumors of the Duodenum and Ampulla of Vater Version 9(for cases diagnosed 01/01/2024+)
        iv. Neuroendocrine Tumors of the Jejunum and Ileum Version 9 (for cases diagnosed 01/01/2024+)
        v. Neuroendocrine Tumors of the Appendix Version 9 (for cases diagnosed 01/01/2024+)
        vi. Neuroendocrine Tumors of the Colon and Rectum Version 9 (for cases diagnosed 01/01/2024+)
        vii. Neuroendocrine Tumors of the Pancreas Version 9 (for cases diagnosed 01/01/2024+)
        viii. Thymus Version 9 (for cases diagnosed 01/01/2025+)
        ix. Lung Version 9 (for cases diagnosed 01/01/2025+)
        x. Diffuse Pleural Mesothelioma Version 9 (for cases diagnosed 01/01/2025+)
        xi. Nasopharynx Version 9 (for cases diagnosed 01/01/2025+)

3. Cancer Registry Management: Principles and Practice, Kendall/Hunt Publishing Company, 4th Edition ISBN: 978-1-7329178-3-5. NCRA members receive a discounted price. Call Kendall/Hunt Publishing directly at 800-228-0810. Non-members can order online at www. kendallhunt.com. Available in e-book format through NCRA.

4. International Classification of Diseases, Clinical Modification, Tenth Revision, Health Care Financing Administration, Public Health Service, U.S. Department of Health and Human Services, 1991. ICD-10-CM ISBN: 978-1-62202-212-0.

5. National Program of Cancer Registries Act, Public Law 102-515, October 24, 1992.
http://www.cdc.gov/cancer/npcr/npcrpdfs/publaw.pdf

6. The SEER Program Coding and Staging Manual, Revised Edition, National Cancer Institute, National Institutes of Health.

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

7. Standards for Cancer Registries, North American Association of Central Cancer Registries (NAACCR).
   http://www.naaccr.org/

   Volume I, *Data Exchange Standards and Record Description*. Intended for programmers, this provides the record layout and specifications for the standard for data exchange.
   https://www.naaccr.org/xml-data-exchange-standard/

   Volume II – *Data Standards and Data Dictionary*. Intended for hospital and central cancer registries, programmers, and analysts, this provides detailed specifications and codes for each data item in the data exchange record layout.
   https://www.naaccr.org/data-standards-data-dictionary/

   Volume III, *Standards for Completeness, Quality, Analysis, and Management of Data.* Intended for central registries, this provides detailed standards for many aspects of the operation of a population-based cancer registry.
   https://www.naaccr.org/standards-for-completeness-quality-analysis-and-management-of-data/

   Volume IV, *NAACCR Standard Edits.* This standard document currently is only made available electronically as a program code and a database. It documents standard computerized edits for data corresponding to the data standards Volume II.
   https://www.naaccr.org/standard-data-edits/

8. Cancer Program Standards 2020: Ensuring Patient-Centered Care, American College of Surgeons Cancer Programs Commission on Cancer
   http://www.facs.org/quality-programs/cancer/coc/standards

9. Anatomy, physiology, pathology, and other similar textbooks are invaluable for coding and abstracting of cancer data. Medical dictionaries, such as Dorland's, Stedman's Blakinston's, Melloni's, or Taber's will also be needed.

For information regarding the National Cancer Registrars Association, Inc., write to:

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Alexandria, VA 22314
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E-mail: info@ncra-usa.org

C. HISTORIC REFERENCES

International Classification of Diseases for Oncology, Second Edition (*ICD-O-2).* World health Organization, Geneva, Switzerland, 1990. Effective for cases diagnosed through 2000.

International Classification of Diseases, Clinical Modification, Ninth Revision, Fourth Edition, (ICD-9-CM), Health Care Financing Administration, Public Health Service, U.S. Department of Health and Human Services, 1991. ISBN: 978-1-45574-569-2. (Available from multiple Web sites by ISBN.)

SEER Summary Staging Manual – 2000: Codes and Coding Instructions, National Cancer Institute, NIH Pub. No. 01-4969, Bethesda, MD, 2001. Effective for cases diagnosed 01/01/2001 through 12/31/2017.
https://seer.cancer.gov/tools/ssm/ssm2000/

SEER Summary Staging Guide - Cancer Surveillance, Epidemiology, and End Results Reporting Program, April 1977 (Reprinted July 1986). Effective for cases diagnosed through 2000.
http://seer.cancer.gov/archive/manuals/historic/ssm_1977.pdf

Collaborative Stage Data Collection System Coding Instructions.
https://seer.cancer.gov/tools/collabstaging/

Multiple Primary and Histology Coding Rules. National Cancer Institute, SEER Program
http://seer.cancer.gov/tools/mphrules/index.html

SEER Program: Self-Instructional Manuals for Tumor Registrars; Surveillance, Epidemiology, and End Results (SEER) Program Informational Guidebook Training Aids. This series of books was published in the 1990's as a mechanism for tumor registrars to learn the procedures for abstracting from medical records of cancer patients and for carrying out functions in the institution-based tumor registry. They are available on-line in both PDF and ZIP formats. To view old manuals

http://seer.cancer.gov/training/manuals/

The set consists of:

Book One - *Objectives and Functions of a Tumor Registry, 1999.*
Book Two - *Cancer Characteristics and Selection of Cases, 1991.*
Book Three - *Tumor Registrar Vocabulary: The Composition of Medical Terms, 1992.*
Book Four - *Human Anatomy as Related to Tumor Formation, 1995.*
Book Five - *Abstracting a Medical Record: Patient Identification, History, and Examinations, 1993.*
Book Six - *Classification for Extent of Disease, 1977.(Out of print)*
Book Seven - *Statistics and Epidemiology for Tumor Registrars, 1994.*
Book Eight - *Antineoplastic Drugs, Third Edition, 1993.*

Cancer Program Standards 2016: Ensuring Patient-Centered Care, American College of Surgeons Cancer Programs Commission on Cancer
http://www.facs.org/quality-programs/cancer/coc/standards

To obtain the additional resources, call or write the publisher directly or call the State Cancer Registry for more information.

CHAPTER 2: CASEFINDING & SETTING UP A REGISTRY

A. OVERVIEW

The accuracy of a statewide database is dependent on the timeliness and completeness of casefinding (the identification of reportable cancer cases) at the hospital level. A variety of casefinding methods must be used since no single method can encompass all the possible medical resources used by cancer patients.

B. REPORTABLE LIST

A reportable list identifies diagnoses that will be included in the registry and those that are to be excluded. The hospital's administration, cancer committee, and physicians; American college of Surgeons' Cancer Program Manual; and the State Policy and Procedure Manual should be consulted when developing the reportable list. Appendix B contains the State reportable list. All diagnoses on the list must be reported to the State Registry. The hospital cancer committee may decide to collect additional diagnoses not on the list, called "Reportable-by-Agreement" cases (e.g., squamous cell carcinomas of the skin). These cases do not need to be reported to the State Registry.

C. METHODS OF CASEFINDING

Definition
Casefinding is a systematic method of identifying all reportable cancer cases. For a hospital, the cases include all patients diagnosed or treated in a hospital, both inpatient and outpatient, during the first course of therapy. Cases identified at autopsy must also be reported.

Responsibility
To assure consistency and completeness, casefinding should be the responsibility of one hospital department that has access to patients' medical records and the appropriate hospital reports and listings. For this reason, the function is most commonly performed in the medical record department. However, it may be performed elsewhere, such as pathology, radiation therapy, oncology, or nursing department, provided there is ready access to the necessary records and a central place for record keeping. The person responsible for casefinding should have a knowledge of medical terminology, especially in the field of cancer diagnosis and treatment. Interdepartmental communication and cooperation are essential for complete casefinding.

Sources of Casefinding
The following are potential sources of cancer patient identification. Other sources, not listed here, may be appropriate, depending on the administrative structure of the hospital. To ensure that all potential sources of case identification are addressed, facilities should use the health information data systems and/or billing systems to print lists of cancer-related diagnostic codes. Casefinding should not be limited to a review of pathology reports. As potential cases are identified, the patient's name and medical record number should be recorded for retrieval of the entire medical record.

1. Pathology and Cytology Departments

   - Pathology reports, including reports with negative findings
   - Bone marrow biopsies
   - Histology reports
   - Cytology reports
   - Hematology reports
   - Autopsy reports
   - Pathology logs
   - Pathology appointment registers

Most newly diagnosed cancer patients have a biopsy or surgical procedure for which a pathology report is written identifying and classifying the excised specimen. All pathology reports, along with

the clinical summary, should be read to identify cases. Cases in which only specimens were reviewed by the reporting hospital may never have a medical record. The coded final histologic diagnoses (in SNOMED) should be reviewed. Sometimes a programmer can prepare a list containing only malignancies.

A negative pathology or cytology report may be a hidden source for finding certain cases. If an excisional biopsy was performed in a physician's office and the patient was later referred to the hospital for additional treatment, the pathology report may be negative if no further cancer was detected. The case should still be reported to the State Registry by the hospital because the patient was referred to the hospital for further diagnosis or treatment.

Example #1: A physician diagnoses a melanoma and performs the excisional biopsy in the office. The patient is then admitted to the hospital for a wide excision. The pathology report does not show any malignancy. Although the pathology report is negative, the case should be reported to the State Registry by the hospital because the patient was referred to the hospital for additional treatment.

Example #2: A physician performs a lumpectomy for breast cancer in the office. The patient is later admitted to the hospital for a modified radical mastectomy. No residual tumor was noted on the pathology report. The hospital must report this case to the State Registry, even though the pathology report is negative.

2. Health Information Management Department (Medical Record Department)
   - Inpatient records
   - Outpatient records
   - Disease or diagnostic index
   - Computerized listings of specific cancer-related ICD-10-CM codes
   - Operation index
   - Admitting lists
   - Discharge lists

   Health information management department personnel may assist in case identification in a number of ways. A regular listing of all cancer cases may be helpful in casefinding. Working with personnel responsible for assembly and analysis of records upon discharge may identify patients overlooked through other reviews. Coders could flag all medical records with malignant diagnoses for review by the Cancer Registrar. If feasible, direct review of all medical records by the cancer registrar assures more complete casefinding. Appendix C lists the ICD-10-CM codes that should be reviewed for eligible cases.

3. Bill and Insurance Department (Patient Accounts)
   - Printouts listing cancer-related diagnostic codes

   Hospital and/or departmental billing systems use diagnostic codes for billing purposes. Computerized billing systems may be used to generate lists of cancer-related diagnostic codes. See Appendix C of this manual for a list of cancer–related codes. Cancer registrars should work with billing department personnel to assess the capabilities of the system and develop the parameters of the report. The process may involve the computer vendor.

4. Radiology Department
   - Radiation therapy treatment summaries
   - Radiation therapy new patient listings
   - Radiation therapy log
   - Radiation therapy schedule
   - Radiation oncology records
   - Nuclear medicine reports
   - Nuclear medicine log
   - Nuclear medicine schedule
   - Diagnostic radiology reports

- Scans

The radiation therapy department can be an important source of casefinding since many patients are treated solely as outpatients and may be missed by other casefinding methods. Radiology records should be made available to the person responsible for casefinding, by either providing copies of the reports or permitting access to the radiation therapy department's patient records. A periodic review of the department's therapy log or schedule will serve as a quality control check and help ensure completeness of casefinding.

5. Outpatients/Clinics/ER
   - Ambulatory/outpatient surgery records
   - Day surgery logs
   - Outpatient scheduling logs
   - CPT codes on outpatient records
   - Emergency room records/logs
   - ENT (ear, nose, throat) clinic records
   - Eye clinic records
   - Skin (melanoma, others) clinic records
   - Mycosis fungoides clinic records
   - OB/GYN clinic records
   - AIDS/Kaposi's sarcoma clinic records

   If outpatient records are not filed in the medical record department, arrangements should be made with the applicable departments and clinics for access to the patient records at a mutually convenient time.

6. Cancer Conference/Tumor Board
   The cancer committee of a hospital is responsible for conducting cancer conferences (tumor boards) to provide consultative services to patients and to educate the medical staff. Attendance at these conferences or review of minutes may identify additional cancer patients.

7. Other Sources of Casefinding
   - Operation/surgery log
   - Operation/surgery schedule
   - Oncology/Hematology records
   - Chemotherapy logs
   - Staff physician's office

Preventing Duplicates
All cancer patients who have been identified by any of the methods described above should be checked against cases in the suspense system (Chapter 2, section D) and the patient index (Chapter 2, section F). If a patient's name is found in either of these places with the same primary cancer, the case has been identified previously and should not be added to the database. These patients may be readmissions for additional treatment, recurrence, progression of or persistent disease, or follow-up.

The information obtained through casefinding should be preserved and used to help complete the abstract (if the case was found in the suspense system) or to complete follow-up (if the case was found in the patient index), if applicable.

D. SUSPENSE SYSTEM

Definition
A suspense system is a file or a list of cancer cases that have been identified but have not yet been completely entered, abstracted, or accessioned into the registry. The file or list serves as a method for keeping track of identified cancer patients until the abstracts are complete.

Purpose
The suspense system has two functions:

- To avoid duplicate case identification, and;
- To serve as a quality control check to assure that over a period of time, all identified cases have been abstracted.

Organization
For convenience in duplicate checking, the suspense system should be arranged alphabetically by month of case identification.

Patient data should include:
Patient name
Date of diagnosis
Medical record number
Cancer primary site

A paper abstract with the above information could be used as the suspense system, or an index card could be completed. The abstracts or cards should be filed alphabetically. *ISCR will no longer accept paper abstracts beginning 1/1/2026

If the patient index described in Section F. is maintained on cards, these cards could be partially completed and used in a suspense file. Once the case is fully abstracted, the card in the suspense file could be moved to the alphabetic patient index and the rest of the information completed.

A suspense system may be set up through your individual registry software. Currently, WebPlus does not support this activity (IN supported free abstracting software). As much information as is initially known about the patient is entered (e.g., name, medical record number, admission date, etc.). In the "Suspense" field, code 1 is entered to indicate the case is in suspense. Records with suspense code 1 are excluded when extensive edits are applied. When the full case is later abstracted, the suspense code 1 should be changed to zero (0) and the edits should be applied. A list can be printed at any time of all patients with suspense code 1 to ensure abstracting has been completed for all cases in the suspense file.

* *After September 10, 2024, the state cancer registry software is SEER Data Management System (SEER DMS).*
As of 02/01/2024 The State of IN Central Cancer Registry supports NAACCR xml file export uploads from outside registry software or direct abstracting submissions into WebPlus by Reporting Hospital Facilities.

E. ACCESSION REGISTER

Definition
The accession register is an annual, sequential listing of all reportable cases included in a hospital's cancer registry. It serves to identify, count, and evaluate the annual caseload. The register can be used to audit other registry files, monitor casefinding, assess the workload, and verify patient identification.

Description
The following items should be included in the accession register:

1. Accession number: The first four digits of the accession number should specify the year that the patient was first seen at the reporting hospital for the diagnosis and/or treatment of cancer following the registry's reference date. The last five digits are a number each case is assigned in sequential order, beginning with 00001 at the start of each new calendar year. Detailed instructions on accession numbers can be found in Chapter 5.
2. Sequence number: Indicate the chronological order of the diagnoses of independent, primary malignancies or reportable benign tumors that occur over the patient's lifetime. Detailed instructions on sequence numbers can be found in chapter 5.
3. Patient name
4. Primary site
5. Date initial diagnosis (or date first seen at the reporting institution)
6. Class of case (optional; see item description in Chapter 5 for further information)

A sample page follows, but the hospital should design the accession register according to its own needs.

Accn. Year & Number	Seq.	Name	Primary Site	Date of Diagnosis	Class
201200001	~~00~~ 01	Brown, John Q.	prostate	01/02/2012	1
201200002	00	Smith, Susan	lung	01/15/2012	0
199700150	02	Jones, Mary (patient's first primary was in 1997)	breast	02/07/2012	1
201200003	00	Green, George	pancreas	03/24/2012	2
201200001	02	Brown, John Q. (patient's first primary was 200100001)	kidney	04/08/2012	1
201200004	00	Washington, Martha	colon	04/21/2012	0

An explanation of how the registry would assign the accession numbers in the 2012 table above follows:

1. 201200001-00 (for the patient's first primary malignancy)
2. 201200002-00
3. 199700150-02 (A patient whose first primary was entered in the registry in 1997 retains the original accession number and only the sequence number changes.)
4. 201200003-00
5. 201200001-02 (For the patient's second of two primaries in 2012, the patient's original accession number remains the same, but the sequence number for his first primary must be changed from 00 to 01.)
6. 201200004-00

The final (highest) accession number for a year will not necessarily be the total number of new cases that year. Patients admitted with new primaries and who had accession numbers assigned in a previous year will be listed but using the original number and therefore will not be counted in the current year's sequence of accession numbers.

F. PATIENT INDEX

Definition
The patient index is a complete alphabetical file or list of all patients, living or dead, identified and reported by the hospital since the reference date (starting date for reporting). Before a patient is added to the registry, the patient index should be checked to see if the patient has already been accessioned.

Description
The following data items must be included in the patient index:

Name
Date of birth
Sex
Medical record number
Accession number
Date of death
Sequence number (for each primary site)
Date of diagnosis (for each primary site)
Laterality (for each primary site)
Site (for each primary site)
Histology (for each primary site)

Below is a sample patient index entry, but the hospital should design their file according to their own needs.

Name:_____DOB:_____Sex:_____

MR#:_____Accn No:_____Date of Death:_____

Seq:____Dx Date:_____Laterality:_____

ICD-O-3 Site:_____Histology:_____

Seq:____Dx Date:_____Laterality:_____

ICD-O-3 Site:_____Histology:_____

Seq:____Dx Date:_____Laterality:_____

ICD-O-3 Site:_____Histology:_____

There should be only ONE entry or card per patient in the patient index. All independent primaries in the same patient are included on the same entry or card. The index should be maintained in alphabetic order and be retained indefinitely.

G. FILING

Hospitals reporting by paper abstracts should keep the **original** abstract form and submit a **copy** of the abstract form to the State Cancer Registry (see Chapter 3). The most efficient filing system for hospitals reporting on paper abstracts is filing all cases in ascending numerical order by the first two digits of the primary site code. *ISCR will no longer accept paper abstracts beginning 1/1/2026

Example: All patients with cancer of the small intestine (C17._) are filed before all patients with cancer of the colon (C18._).

Within each site, cases are separated by accession year. Within each accession year, cases are filed alphabetically.

Example: All patients with colon cancer in 1994 will be filed alphabetically behind all patients with colon cancer in 1993.

The file of abstracts in site order could serve as a primary site index, making records more easily retrievable for studies.

The cancer registry database, original abstracts, any copies of them, and associated documentation must be regarded as confidential medical records and their storage should comply with applicable hospital and state regulations for confidentiality and security of records. Abstracts are retained indefinitely in electronic format or hard copy.

CHAPTER 3: REPORTING

A. OVERVIEW

This chapter explains the cases and types of diagnoses to be reported, who should submit abstracts, when abstracts should be submitted, and how they should be submitted.

B. CASES TO REPORT TO THE STATE REGISTRY

1. **General Requirements**
   - All confirmed cases of reportable tumors diagnosed and/or initially treated in Indiana must be reported to the State Cancer Registry, as specified in this section. Reportable diagnoses are listed in Appendix B.
   - Confirmed cases include clinically diagnosed patients (not microscopically confirmed) as well as microscopically confirmed diagnoses. If a recognized medical practitioner documents that a patient has cancer, the diagnosis is reportable. Terms that constitute a clinical diagnosis can be found in Chapter 4.
   - Reportable cases include inpatients and outpatients (including hospital-affiliated ambulatory care settings).

2. **Required Cases**
   a. In situ and frank malignancies – those with an *International Classification of Diseases for Oncology, Third Edition,* 2000 (*ICD-O-3.2*) fifth digit behavior code of /2 or /3. These diagnoses appear on the Reportable List of Malignancies in Appendix B.

      Exceptions (Not Reportable):
      - Preinvasive cervical neoplasia (CIS and CIN III) diagnosed 01/01/2003 or later are NOT reportable;
      - Prostatic intraepithelial neoplasia, grade III (PIN III) diagnosed 01/01/2003 or later;
      - Basal cell and squamous cell carcinoma of skin (*ICD-O-3.2* primary site codes C44.0-C44.9 with histology codes 8000-8110) diagnosed 01/01/2003 or later.
      - Adenocarcinoma in situ, HPV-associated (C530-C531, C538-C539) (8483/2)
      - Adenocarcinoma in situ, HPV-independent (C530-C531, C538-C539) (8484/2)
      - Uterine tumor resembling ovarian sex cord tumor (8590/1)
      - Osteoblastoma (9200/1) *behavior changed from /0 to/1 but remains not reportable
      - Osteofibrous dysplasia-like adamantinoma (9261/1)
      - Tubular adenoma, high grade (8211/2)
      - Tubulovillous adenoma, high grade (8263/2)
      - Villous adenoma, high grade (8261/2)

   b. If diagnosed before 01/01/2003, basal cell and squamous cell carcinoma of skin (*ICD-O-3.2* primary site codes C44.0-C44.9 with histology codes 8000-8110) that meets at least one of the following conditions at the time of diagnosis:

      (1) Primary tumor more than 5 centimeters in greatest dimension;
      (2) Primary tumor that has invaded deep extradermal structures such as cartilage, skeletal muscle, or bone;
      (3) Primary tumor with regional node metastases;
      (4) Primary tumor with metastasis to distant sites.

c. Basal cell and squamous cell carcinoma (*ICD-O-3.2* histology codes 8000-8110) that originates in a mucous membrane site:

- Lip C00.0 – C00.9
- Anus C21.0
- Labia C51.0 – C51.1
- Clitoris C51.2
- Vulva C51.8 – C51.9
- Vagina C52.9
- Prepuce C60.0
- Penis C60.1 – C60.9
- Scrotum C63.2

d. Pilocytic/juvenile astrocytoma, listed as 9421/1 in *ICD-O-3.2*, is required and should be reported as 9421/3.

(Non-Malignant CNS Reportable): *Beginning 01/01/2023 Pilocytic/juvenile astrocytoma is coded to 9421/1 for ALL SITES, they will no longer be collected with malignant behavior /3. No need to update cases prior to 01/01/2023.

Pre 2023 & 2023+- When the primary site is optic nerve and the diagnosis is either optic glioma or pilocytic astrocytoma, the behavior is non-malignant and coded 9421/1.

e. The *ICD-O-3.2* code for Carcinoid tumor, NOS, of appendix (8240/1) is obsolete in 2015. Carcinoid tumors of the appendix must be coded to 8240/3 and are required to be reported.

f. All benign and borderline (behavior codes /0 and /1) intracranial and central nervous system tumors diagnosed January 1, 2004 or later. (ICD-O-3.2 primary site codes C70.0-C72.9, C75.1-C75.3.)

g. Analytic cases (see Item 28 in Chapter 5 for further information on analytic and nonanalytic cases). Analytic cases include the following:

(1) All new malignancies diagnosed at the reporting facility on or after January 1, 1987 (class of case 00).
(2) All malignancies initially diagnosed and treated at the reporting facility for all or part of the first course of treatment on or after January 1, 1987 (class of case 10, 13, or 14).
(3) All malignancies initially diagnosed in a staff physician's office on or after January 1, 1987 and treated at the reporting facility for all or part of the first course of treatment (class of case 11 or 12).
(4) All malignancies initially treated at reporting facility for all or part of the first course of treatment on or after January 1, 1987 (class of case 20, 21, or 22).

This includes patients who previously have been diagnosed with a cancer prior to January 1, 1987 and have a new primary malignancy diagnosed at the reporting facility on or after January 1, 1987. (Only the new malignancy diagnosed on or after January 1, 1987 must be reported to the State Cancer Registry.) Do not report the malignancy diagnosed before January 1, 1987.

h. Nonanalytic class of case 32 diagnosed on or after January 1, 1987. Class 32 includes cases first diagnosed elsewhere and all of the first course therapy elsewhere. The reporting facility diagnosed and/or treated the recurrence or progression of a malignancy diagnosed January 1, 1987 or later.

i. Cases with diagnoses (for example, VIN III), required by the State, but not by CoC that are diagnosed and/or treated at the reporting facility on or after January 1, 1987 (Nonanalytic class of case 34 or 36).

j. Nonanalytic class of case 35 or 37 diagnosed on or after January 1, 1987. Class 35 or 37 includes cases first diagnosed and/or first course of therapy at the reporting facility before the registry's reference date. Class of case 35 or 37 would be applicable only for a registry with a reference date later than 1987.

Example 1: Hospital A changed their reference date from 1987 to 1992. In 1993, a patient is admitted who was diagnosed and treated for a melanoma at Hospital A in 1990 and has returned for a recurrence. The case is class 35 for the hospital and should be reported to the State Registry in 1993 if not previously reported when diagnosed.

Example 2: Hospital A changed their reference date from 1987 to 1992. In 1993, a patient is admitted with a second primary. The first primary, treated at Hospital A in 1990, is class of case 37 for the hospital and should be reported to the State Registry in 1993 if not previously reported when diagnosed.

k. Patients first diagnosed at autopsy (Nonanalytic class of case 38).

l. Patients diagnosed and treated only in a staff physician's office (Nonanalytic class of case 40 or 41). Reportable by the hospital only if the hospital collects class 40 and 41 cases. Otherwise, reportable by the physician's office.

m. The types of cases list below <u>are</u> reportable to the State Registry, though not reportable by CoC. Since documentation for these cases may be limited, report all information available either in your usual format, by paper abstract, or by sending copies of pertinent medical record documentation. *ISCR will no longer accept paper abstracts beginning 1/1/2026

(1) Pathology-only cases (Nonanalytic class of case 43).

(2) Patients seen in consultation to confirm a diagnosis or first course treatment plan (Nonanalytic class of case 30).

Example: A patient comes to the institution for a second opinion. Staff physicians order diagnostic tests and support the original treatment plan. The patient returns to the other institution for treatment.

n. Beginning 1/1/25 Post Transplant Lymphoproliferative Disorder (PTLD) behavior changed, formerly 9971/1, PTLD is now reportable as 9971/3.

C. CASES <u>NOT</u> REQUIRED

1. Cases with an *International Classification of Diseases of Oncology, Third Edition,* 2000 (*ICD-O-3.2*) fifth digit behavior code of /0 (benign) or /1 (uncertain or borderline), which are the codes for precancerous conditions or benign tumors.

Exceptions (Reportable):

- Pilocytic/juvenile astrocytoma, listed as 9421/1 in *ICD-O-3.2*, is required and should be reported as 9421/3 unless the primary site is optic nerve (C723). Report behavior as non-malignant for optic nerve pilocytic/juvenile astrocytoma diagnosed 2004 or later.
- All benign and borderline intracranial and central nervous system tumors diagnosed January 1, 2004 or later are reportable. (*ICD-O-3.2* primary site codes C70.0-C72.9, C75.1-C75.3.)
- Carcinoid tumor, NOS, of appendix, listed as 8240/1 in *ICD-O-3.2*, is required effective 1/1/2015 and should be coded to 8240/3.
- Mature teratoma, listed as 9080/0 in *ICD-O-3.2,* of the testes in adults is malignant and reportable as 9080/3. Mature teratoma in prepubescent children continues to be non-reportable (9080/0).
- High-grade astrocytoma with piloid features (HGAP) (9421/3) as of 01/01/2023
- Lymphoangioleiomyomatosis (9174/3) as if 01/01/2023; behavior /1 changed to /3
- Mesothelioma in situ (9050/2)
- Diffuse leptomeningeal glioneuronal tumor (9509/3) reportable as of 01/01/2023

- Low-grade appendiceal mucinous neoplasm (LAMN) is reportable
- Early or evolving melanoma, in situ and invasive, reportable as of 01/01/2021 (pre 2021 do not report)
- All GIST tumors (except those stated to be benign) are reportable as of 1/1/2021, ICD-O-3.2 behavior /3
- Nearly all thymomas are reportable as of 01/01/2021, behavior code /3 per ICD-O-3.2. *Exceptions:* Microscopic thymoma or thymoma, benign (8580/0); micronodular thymoma with lymphoid stroma (8580/1); ectopic hamartomatous thymoma (8587/0)
- The following **are reportable** (not a complete list):
    - Lobular carcinoma insitu (LCIS); Intraepithelial neoplasia, grade III
    - Anal intraepithelial neoplasia III (AIN III) of the anus or anal canal (C210-C211)
    - High grade biliary intraepithelial neoplasia (BiIN III) of the gallbladder (C239)
    - Laryngeal intraepithelial neoplasia III (LIN III) (C320-C329)
    - Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast (C500-C509)
    - Pancreatic intraepithelial neoplasia (PanIN III) (C250-C259)
    - Penile intraepithelial neoplasia, grade III (PeIN III) (C600-C609)
    - Squamous intraepithelial neoplasia III (SIN III) excluding cervix (C53_) and skin sites coded to C44_
    - Vaginal intraepithelial neoplasia III (VAIN III) C529
    - Vulvar intraepithelial neoplasia III (VIN III) C510-C519
- Noninvasive mucinous cystic neoplasm (MCN) of the pancreas with high grade dysplasia is reportable. MCN replaced term “mucinous cystadenocarcinoma, non-invasive”.
- Urine cytology positive for malignancy is reportable for diagnosis year 2013 and forward
    - Exception: when a subsequent biopsy of a urinary site is negative do not report

2. If diagnosed 01/01/2003 or later, all basal cell and squamous cell carcinoma of skin (*ICD-O-3.2* primary site codes C44.0-C44.9 with histology codes 8000-8110).

   If diagnosed before 01/01/2003, basal cell and squamous cell carcinoma of skin that are in situ or that are invasive and 5 centimeters or less in greatest dimension with no lymph node or distant metastasis.

3. Analytic cases (class of case codes 00-22) who were first diagnosed or first treated at the reporting facility on or after January 1, 1987 and return to the facility for:

   a. A recurrence of that same primary;
   b. Subsequent treatment;
   c. Progression of recurrent disease (disease free period); or
   d. Continued or persistent disease (never disease free).

   Note: An abstract would have been submitted when the patient was first diagnosed or first treated. Once a case has been accessioned into a registry, it is not re-accessioned or reported if the patient returns to the hospital for that same primary.

4. Nonanalytic class of case 30-33 diagnosed before January 1, 1987. Class 30-33 includes cases first diagnosed elsewhere and all of the first course therapy elsewhere. If the reporting facility is treating the recurrence or progression of a malignancy diagnosed before January 1, 1987, the case should not be reported to the state.

5. Nonanalytic class of case 35 and 37 diagnosed before January 1, 1987. Class 35 and 37 includes cases diagnosed and/or first course of therapy at the reporting facility before the registry’s reference date. Patients with the following situations would be non-reportable class of case 35 and 37:

   Patients first diagnosed before January 1, 1987 who:
   a. Received no treatment after being diagnosed;
   b. Received first course of treatment before January 1, 1987;
   c. Received first course of treatment before January 1, 1987 and subsequent treatment on or after January 1, 1987;

d. Received first course of treatment before January 1, 1987 and had a recurrence of that same primary on or after January 1, 1987.

6. Patients who receive transient care to avoid interrupting a course of therapy started elsewhere (class of case 31). Please verify with the State Cancer Registry that such patients who are Indiana residents have been reported by the other facility.

   Example 1: A patient is visiting relatives in the area. The oncology department at the reporting facility dispenses the scheduled chemotherapy.

   Example 2: Another institution sends a patient to the reporting facility because of equipment failure. The reporting facility administers the radiation therapy until the equipment is repaired. The patient returns to the original institution to complete therapy.

7. Patients with active cancer who are admitted for an unrelated medical condition. Please verify with the State Cancer Registry that such cases have been reported.

   Example: A patient with active prostate cancer enters the reporting facility's cardiac care unit for cardiac care only.

8. Patients with a history of cancer who currently have no evidence of the disease. Please verify with the State Cancer Registry that such cases have been reported.

9. Patients admitted to a designated hospice unit or home care service. Please verify with the State Cancer Registry that such cases have been reported.

10. Patients admitted for terminal supportive care only. Please verify with the State Cancer Registry that such cases have been reported.

11. Class of case 49 (diagnosed by death certificate only). The State Cancer Registry will collect cancer data on these patients after all reasonable efforts to obtain information from a health care provider have failed.

12. Residents of a foreign country.

13. Annual follow-up on all cases (optional reporting).

14. Hospitals may abstract cases that are not required by the State Registry, but are important for their own clinical, administrative, management, or marketing purposes. These patients often receive services and use the resources of the hospital (e.g., chemotherapy, radiation, lab tests, etc.). These cases should not be reported to the State Registry. Examples include non-reportable localized basal cell carcinoma of the skin and class 35 or 37 cases diagnosed before 1987.

15. Hospitals are instructed to abstract LCIS of the breast (Lobular Carcinoma Insitu; C50_) as "Report to State Only" cases for diagnosis years 2018 and forward. This is to align with the AJCC 8th Edition and STORE Manual. These types of cases are reported as class 34/36 & 99. Class 00 would be reported as 99 if diagnosis only (no treatment performed) at the reporting facility. SEER and NPCR are collecting this type of cancer.

D. DATA ITEMS TO REPORT

1. **Analytic Cases**
   Required and optional data items to report to the State Registry for analytic cases are identified in Chapter 5 of this manual. The items are listed in a table of the State data set in Chapter 5 and are presented in the pages following the table with descriptions, codes, formats, definitions, rules, and instructions.

2. **Reportable Nonanalytic Cases**
Since hospitals may have limited information about nonanalytic cases (reportable if diagnosed after January 1, 1987), a minimal data set for these cases is presented in the table below. Apply the codes, definitions, and rules in chapter 5 for these items and record them in either the paper or a computerized abstract. If the information for an item is not available, leave the item blank or code it according to the vendor's instructions for "unknown." *ISCR will no longer accept paper abstracts beginning 1/1/2026

No.	Item	Notes
1.	Reporting hospital	ID number
2.	Abstracted by	Abstractor's initials
3.	Type of reporting source	
4.	Patient last name	
5.	First name	
6.	Middle name	
7.	Birth surname	If known
8.	Alias	If known
9.	Street address at diagnosis	Not current address; if unknown, record "unknown"
11.	City/town at diagnosis	Not current city/town; if unknown, record "unknown"
12.	State at diagnosis	Not current state; "ZZ" if unknown
13.	ZIP code at diagnosis	Not current ZIP; if unknown, record 9's
14.	County at diagnosis	Not current county; if unknown, record 9's
15.	Social Security Number	If known; if unknown, record 9's
16.	Date of birth	If known; if unknown, record 9's
18.	Medical record number	
19.	Sex	
20.	Race/Spanish origin	At least race, if known
23.	Other primary tumor(s)	If known
24.	Date of first contact	At your hospital for this tumor
25.	Accession year this primary	
26.	Hospital accession number	If assigned
27.	Sequence number	
28.	Class of case	
29.	Referred from	If known
31.	If diagnosed elsewhere, record where	Name, phone number, and address of diagnosing physician, lab, clinic, etc., if known
32.	Date of initial diagnosis	If unknown, estimate year
33.	Primary site	Not metastatic site
34.	Laterality	For original, primary site, if known
35.	Diagnostic confirmation	If known
36.	Histology/behavior/grade	For original, primary site, if known
37.	Description of diagnosis	Narrative text of site and histology, if known
69.	Description of treatment	Narrative text, if known
70.	Date of last contact/death	
71.	Vital status	
72.	Cancer status	If known

No.	Item	Notes
73.	Remarks	Any other pertinent information

E. WHO SHOULD SUBMIT REPORTS

The hospital that first diagnoses a case in 1987 or later is responsible for submitting an abstract to the State Cancer Registry.

A hospital that performs part or all of the first course treatment for cases diagnosed in 1987 or later is responsible for submitting an abstract to the State Cancer Registry.

A hospital that treats recurrence or progression of a malignancy first diagnosed elsewhere in 1987 or later and all of first course of treatment performed elsewhere is responsible for submitting an abstract to the State Cancer Registry.

The staff physician's office is considered an extension of the hospital. Cases of patients who are diagnosed or treated in a staff physician's office and referred to the hospital for definitive therapy must be reported as though they were diagnosed at the hospital. If these patients were referred to another institution for their first course of treatment, then their cases need not be included. Patients diagnosed and treated only in a staff physician's office (class of case 40 or 41) are to be reported if such cases are collected by the hospital. If not reported by the hospital, these cases must be reported by the physicians' offices.

When the distinction between a hospital-based department and a freestanding facility cannot readily be made (e.g., a radiation therapy group practice versus a hospital unit) the ownership of the medical record should be used to determine whether a case must be reported by the hospital. The owner of the medical record is responsible for reporting the case to the State Cancer Registry.

F. WHEN TO SUBMIT REPORTS

Facilities must complete and submit reports of confirmed cases of reportable tumors to the State Cancer Registry no later than six (6) months following the date the patient comes under the care of the reporting facility. Facilities should report on a schedule based on the size of their annual caseload. The minimum reporting requirements for each caseload range is provided in the table below. More frequent reporting is encouraged so that the State database remains as current as possible for analytic purposes.

REPORTING SCHEDULE	
Average Number of Cases Diagnosed per Year	**Minimum Frequency for Reporting to the State**
1-59	Biannually
60-149	Quarterly
150-299	Every other month
≥ 300	Every month

G. HOW TO SUBMIT REPORTS

1. **Hospitals With Computerized Systems**
   a. Hospitals with computerized registries should submit reports to the State Cancer Registry in an acceptable, machine-readable format (NAACCR format for those using other systems) within the time frame described in this chapter

b. Make sure all cases abstracted since the previous submission are selected for each new submission. Selecting cases by a range of accession numbers will omit patients with an earlier accession number who have a new primary. Contact your software vendor for procedures to ensure all cases are reported to the State Cancer Registry.

c. Submitting by Web Plus
Effective 2/1/2024 Indiana State Cancer Registry requires you to submit your data in NAACCR xml format using Web Plus.

d. Submitting on Diskettes:
Effective July 2009 the State Cancer Registry can no longer process data submitted on diskettes.

e. The hospital should keep a record of cases submitted to the State. The State Cancer Registry personnel will keep track of the date and number of cases received from each hospital.

2. **Hospital Using Paper Forms-*ISCR will no longer accept paper abstracts beginning 1/1/2026**

a. Hospitals should submit reports to the State within the time frame described in this chapter, using the "Hospital Abstract" form designed and approved by the State Cancer Registry. Computerized registries may use the form to submit reportable nonanalytic cases that are not abstracted into their registry systems.

Forms may be obtained, free of charge, by calling or writing the State Cancer Registry.

Patrick Sweany
Indiana State Cancer Registry
Indiana Department of Health
2 North Meridian Street, Section 6-B
Indianapolis, IN 46204-3010

Office: (317) 233-7158
Fax: (317) 233-7722
E-mail: psweany@health.in.gov

b. Attach a copy of the pathology report to the abstract form. State Cancer Registry staff need the reports to substantiate the codes.

c. When sending in more than one abstract for multiple tumors on a patient, do not staple abstracts on different tumors together, as they may be overlooked. Do staple copies of medical record documentation about the reported tumor to the applicable abstract.

d. The hospital should make a legible copy of the original abstract and mail the copy to the State Cancer Registry, keeping the original at the hospital. Illegible abstracts will be returned to the hospital.

e. Ensure that abstracts are treated with the same level of security and confidentiality as the medical record. The abstracts are abbreviated medical records and should be treated as such. A full discussion of confidentiality is found in Chapter 8 of this manual.

f. The hospital should keep a record of abstracts mailed to the State Cancer Registry, noting the date and number submitted. The State Cancer Registry personnel will keep track of the number of abstracts and date received from each hospital.

g. Envelopes containing copies of the abstracts should be carefully sealed and labeled "CONFIDENTIAL MEDICAL INFORMATION." The envelope should be clearly addressed:

Indiana State Cancer Registry
Indiana Department of Health
2 North Meridian Street, Section 6-B
Indianapolis, IN 46204-3010

3. **Other Forms**
   a. Correction and Follow-Up Form
      Chapter 6 of this manual describes a “Correction and Follow-Up Form” and instructions for completing it. Corrections or annual follow-up data on previously submitted Hospital Abstracts may be reported on this form.

   b. Correction Form for Multiple Patients
      Chapter 6 also describes a “Correction Form for Multiple Patients” and instructions for completing it.

   These forms may be obtained by calling or writing the State Cancer Registry.

CHAPTER 4: GENERAL DEFINITIONS FOR CODING

A. INTRODUCTION

The State Cancer Registry uses definitions published by national standard-setting organizations in order to ensure that its instructions and the data collected are consistent with those from other registries. The standard-setting organizations include the American College of Surgeons, Commission on Cancer (ACoS/CoC); the North American Association of Central Cancer Registries (NAACCR); and the National Cancer Institute's SEER (Surveillance, Epidemiology, and End Results) program.

B. GUIDELINES FOR INTERPRETATION OF TERMINOLOGY

The overall priority for using information to determine tumor involvement is pathological, operative, then clinical findings. The medical practitioner may use ambiguous terms when describing a clinical diagnosis or extent of disease in relation to tumor invasion of an organ or structure, especially when there is no cytologic or histologic proof of disease extension. When there are questions concerning terminology, consult with a physician or pathologist. The following lists should be used when the terminology is vague or ambiguous.

Terms That Indicate Clinical Diagnosis or Tumor Involvement/Extension

- adherent to
- apparent
- apparently
- appears to
- comparable with
- compatible with
- consistent with
- contiguous/continuous with
- encroaching upon
- extension - to, into, onto, or out onto
- favor(s)
- features of
- fixation (to another structure)
- fixed (involvement of other organ/tissue)
- impending perforation of [2]
- impinging upon [2]
- impose, imposing on [2]
- incipient invasion
- induration (for breast cases)
- infringe, infringing [2]
- into
- intrude
- invasion - to, into, onto, or out onto
- malignant appearing
- matted (for lymph nodes only)
- most likely
- neoplasm (only for C70.0-C72.9, C75.1-C75.3 diagnosed 01/01/04 and later)
- obliterate
- onto
- out onto
- overstep [2]
- presumed
- probable
- probably
- protruding into (unless encapsulated)
- suspect
- suspected
- suspicious (for) [1]
- to
- tumor (only for C70.0-C72.9, C75.1-C75.3 diagnosed 01/01/04 and later)
- violate
- typical of
- up to

[2] These terms are considered involvement by the SEER Program and non-involvement by the Statistical Analysis and Quality Control Center at Fred Hutchinson Cancer Research Center in Seattle, WA. Consult the attending physician regarding these terms.

Example: A chest x-ray is consistent with a carcinoma of the right upper lobe. Final diagnosis is probable carcinoma of the right lung. The case should be abstracted and reported.

[1] **Exception:** If a cytology specimen is reported as "suspicious," do not interpret this as a diagnosis of cancer unless it is confirmed by a positive biopsy or a physician's clinical assessment (For diagnosis years 2022 forward: Use cytology w/ ambiguous

terminology date, if followed by a positive biopsy or clinical confirmation of cancer, as date of diagnosis).

*Pre-2022 diagnosis year: Report date of diagnosis as date of clinical confirmation of cancer or positive biopsy, do not use date of cytology with ambiguous terminology.

2022+ Dx Year Example: *Cytology suspicious for cancer 01/01/2022 and pathology is positive on 02/01/2022, positive pathology supports the cytology diagnosis and the date of the cytology (01/01/2022) may be used as the reported date of diagnosis. (See STORE 2022, 1st Example, page 126).*

2021 Dx Year Example: *Cytology suspicious for cancer 01/01/2021 and pathology is positive on 02/01/2021, no clinical confirmation of cancer. The date of positive pathology (02/01/2021) must be used as the reported date of diagnosis. (See STORE 2021, 1st Example, page 134).*

Terms That Do Not Indicate Clinical Diagnosis or Tumor Involvement

- abuts
- along side
- approaching
- approximates
- attached
- borders on
- cannot be excluded/ruled out
- efface, effacing, effacement
- encased, encasing
- encompass(ed)
- entrapped
- equivocal
- extending up along
- extension over
- extension to without invasion/involvement of
- lesion
- kiss, kissing
- mass
- matted (except for lymph nodes)
- next to
- possible
- potentially malignant
- questionable
- reaching
- rule out
- suggests
- up along
- up over
- very close to
- without perforation of
- worrisome

Example: The final diagnosis is possible carcinoma of the breast. This case should not be abstracted and reported

- Do not consider any PI-RADS, BI-RADS, or LI-RADS as diagnostic terms (per NPCR) unless a statement of malignancy is documented within the same report.

  SEER Reporting Requirements do not apply for IN State Reporters at this time: *From the 2025 SEER Program and Staging Manual, page 101,#3-Note: Appendix E in the 2025 SEER Program Coding and Staging Manual lists which PI-RADS, BI-RADS, and LI-RADS are reportable versus non-reportable. If reportable, use the date of the imaging procedure as the date of diagnosis when this is the earliest date and there is no information to dispute the imaging findings.*

CHAPTER 5: CODING INSTRUCTIONS

OVERVIEW

An abstract is a summary of pertinent information about the patient, the cancer, the treatment, and outcome. A paper abstract for reporting such information is available for facilities with non-computerized registries. An abstract is used to collect the following three categories of information:

Patient and Hospital Identification
This includes data items related primarily to demographic information about the patient and hospital-specific information.

Cancer Identification
This includes data items related primarily to information about the patient's tumor or cancer.

Treatment Data
This includes treatment data and follow-up information.

Chapter 5 explains how to complete each item within the three categories. Rules and codes for recording the information are consistent with the *Standards for Oncology Registry Entry (STORE)* to the extent possible and apply to both paper and computer abstracting unless they conflict with an alternative software vendor's instructions. As with the *STORE*, abstracters should use the rules and codes in this manual only for cases diagnosed January 1, 2021 and later unless instructed otherwise. Chapter 3, Section B. lists the types of cases to be reported on an abstract**. *ISCR will no longer accept paper abstracts beginning 1/1/2026**

WHEN TO ABSTRACT A CANCER CASE

1. Cancer case information should be abstracted after complete work-up, cancer staging, and planned first course of treatment have been initiated. The first course of treatment is generally initiated within four months after the cancer is initially diagnosed. With the exception of early deaths, cases should not be abstracted less than four months after diagnosis.

2. Cases are due at the State Cancer Registry no later than six months following the date the patient comes under the care of the reporting facility.

3. Follow-up items are required and should be completed at the time the rest of the case is abstracted. Subsequent, annual follow-up information is optional, but may be reported if desired. See Chapter 6 for details on how to submit annual follow-up information at a later date.

4. There is no time limit for making revisions that give better information about the original diagnosis or stage. Data should be coded using the most accurate information available for an up-to-date and factual database. Over time, information that was missing when the case was first abstracted may be added to the patient's medical record. Such additions may contain new information. The latest or most complete information available should be used. Thus, it is acceptable to change the primary site, histology, and extent of disease (staging data) as information becomes more complete.

   Note: This does not mean that if the patient's disease progresses, you should change the original stage to a higher stage. Staging should reflect only information available through completion of surgery(ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer. However, if the original stage is later found to be incorrect, it would be appropriate to change the stage to the correct code.

GENERAL ABSTRACTING INSTRUCTIONS AND DEFINITIONS

1. **Each primary cancer should be abstracted only once by a facility. However, if a patient is diagnosed with more than one primary cancer, whether simultaneously or at different times, a separate abstract must be completed for each primary cancer.**

2. Enter all information accurately. Entries on the paper abstract should be printed legibly. *ISCR will no longer accept paper abstracts beginning 1/1/2026

3. The following terms are used throughout this chapter to indicate type, justification, and length of data fields:

Numeric:	The field will accept numbers only.
Alphabetic:	The field will accept letters only.
Alphanumeric:	The field will accept either letters or numbers, but no special characters.
Text:	The field will accept any letter, number, symbol, or space.
Left-Justified:	Data are to be entered starting at the first space toward the left. Leave unused spaces blank unless otherwise instructed.
Right-Justified:	Data are to be entered so that the last character falls in the last space on the right in the field. Leave unused spaces blank or zero fill, as directed.
Length:	Length refers to the number of characters in each data field.

4. The following abbreviations are used throughout Chapter 5:

ACoS	American College of Surgeons
AJCC	American Joint Committee on Cancer
CDC	Centers for Disease Control and Prevention
CoC	Commission on Cancer
CS	Collaborative Stage
STORE	*Standards for Oncology Registry Entry* (from Vol. II, Standards of the Commission on Cancer, ACoS)
ICD-O-2	*International Classification of Diseases for Oncology*, Second Edition, 1990
ICD-O-3	*International Classification of Diseases for Oncology*, Third Edition, 2000
ICD-O-3.2	*International Classification of Diseases for Oncology*, Third Edition, Second Revision, 2021
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
NAACCR	North American Association of Central Cancer Registries
NPCR	National Program of Cancer Registries
NPI	National Provider Identifier
SEER	Surveillance, Epidemiology, and End Results (National Cancer Institute program)

STATE DATA SET
Indiana State Cancer Registry Required Status Table for Cases Diagnosed in 2023

Required Status Key
R Data elements required by National Program of Cancer Registries (NPCR) and/or the Indiana State Cancer Registry (ISCR).
R# Required; central registries may code available data using either SEER or CoC data items and associated rules
R* Data elements required if available.
RS Data elements required for specific sites only.
RS* Data elements required, if available, for specific sites only.
R^ Text requirements that may be met with one or several text block fields.
RH Required historically.
D Required data elements derived from other elements by computer algorithm.
O Optional data elements.

ITEM (Date Implemented)	NAACCR ITEM #	STATUS
Suspense case		O
Where, if diagnosed elsewhere (text)		R^
Description of size (text)		R^
Other primary tumors (text)		R^
Record type (computer-generated)	10	R
Central tumor registry number - for State use only	20	R
Registry ID	40	R
NAACCR record version	50	R
City/town at diagnosis	70	R
State at diagnosis	80	R
County at diagnosis	90	R
County at DX Geocode 1990 (Derived) - for State use only (01/01/2016)	94	D
County at DX Geocode 2000 (Derived) - for State use only (01/01/2016)	95	D
County at DX Geocode 2010 (Derived) - for State use only (01/01/2016)	96	D
County at DX Geocode 2020 (Derived) - for State use only (01/01/2018)	97	D
Postal code at diagnosis	100	R
Census tract 2020 - for State use only	125	D
Census tract 2000 - for State use only	130	RH
Census tract 2010 - for State use only	135	R*
Census tr poverty indictr - for State use only (01/01/2014)	145	R
Race 1-5	160-164	R
Spanish/Hispanic origin	190	R
NIHIA derived Hispanic origin - for State use only	191	D
IHS link - for State use only	192	R*
Race—NAPPIIA (derived API) - for State use only	193	R
Computed ethnicity - for State use only	200	R
Computed ethnicity Source - for State use only	210	R
Sex	220	R
Age at diagnosis	230	R
Date of birth	240	R

ITEM (Date Implemented)	NAACCR ITEM #	STATUS
Date of birth flag (01/01/2010-12/31/2022)	241	R
Birthplace (01/01/2013-12/31/2023)	250	RH*
Birthplace – state (01/01/2013)	252	R*
Birthplace – country (01/01/2013)	254	R*
Census occupation code 1970-2000 - for State use only	270	R*
Census industry code 2010 - for State use only (01/01/2013)	272	R*
Census industry code 1970-2000 - for State use only	280	R*
Census occupation code 2010 - for State use only (01/01/2013)	282	R*
Occupation source - for State use only	290	R*
Industry source - for State use only	300	R*
Usual occupation (text)	310	R*
Usual industry (text)	320	R*
Occupation/industry coding system	330	R*
Tobacco Use Smoking Status (01/01/2022)	344	R*
Census tract certainty 2000 - for State use only	365	RH
GIS coordinate quality - for State use only	366	R*
Census tract certainty 2010 - for State use only	367	R*
Census tract certainty 2020 - for State use only	369	D
Sequence number--central - for State use only	380	R
Date of initial diagnosis	390	R
Date of diagnosis flag (01/01/2010-12/31/2022)	391	R
Primary site	400	R
Laterality	410	R
Histologic type (1992-2000) ICD-O-2	420	RH
Behavior code (1992-2000) ICD-O-2	430	RH
Grade (discontinued after 12/31/2017)	440	RH
Grade clinical (01/01/2018)	3843	R
Grade post-therapy clinical (yc) (01/01/2021)	1068	R
Grade pathological (01/01/2018)	3844	R
Grade post-therapy path (yp) (01/01/2018)	3845	R
Grade path value (01/01/2011-12/31/2013)	441	RH
Grade path system (01/01/2011-12/31/2013)	449	RH
Site coding system – current	450	R
Morphology coding system – current	470	R
Diagnostic confirmation	490	R
Type of reporting source	500	R
Casefinding source (01/01/2012)	501	R*
Histologic type ICD-O-3	522	R
Behavior code ICD-O-3	523	R
Facility ID number	540	R
NPI-Reporting Facility	545	R*
Accession number- -Hospital (not collected by NPCR)	550	R
Sequence number- -Hospital (not collected by NPCR)	560	R

ITEM	(Date Implemented)	NAACCR ITEM #	STATUS
Abstracted by (not collected by NPCR)		570	R
Date of first contact for this primary		580	R
Date of first contact flag	(01/01/2010-12/31/2022)	581	R
Class of case		610	R
Primary payer at diagnosis		630	R*
Rx Hosp-Recon Breast	(01/01/2018)	751	O
Tumor Size Summary	(01/01/2016)	756	R
Summary Stage 2018	(01/01/2018)	764	R
SEER Summary Stage 2000 (Cases diagnosed 2001-2003, 01/01/2015-12/31/2017)		759	RH
SEER Summary Stage 1977 (Cases diagnosed through 12/31/2000)		760	RH
Tumor size (Cases diagnosed through 12/31/2003)		780	RH
Regional nodes positive		820	R
Regional nodes examined		830	R
Pathologic T	(01/01/2014 - 12/31/2017)	880	RH
Pathologic N	(01/01/2014 - 12/31/2017)	890	RH
Pathologic M	(01/01/2014 - 12/31/2017)	900	RH
Pathologic stage group	(01/01/2014 - 12/31/2017)	910	RH
Pathologic stage (prefix/suffix) descriptor	(01/01/2014 - 12/31/2017)	920	RH
Stage by (pathologic stage)		930	
Clinical T	(01/01/2014 - 12/31/2017)	940	RH
Clinical N	(01/01/2014 - 12/31/2017)	950	RH
Clinical M	(01/01/2014 - 12/31/2017)	960	RH
Clinical stage group	(01/01/2014 - 12/31/2017)	970	RH
Clinical stage (prefix/suffix) descriptor	(01/01/2014 - 12/31/2017)	980	RH
Stage by (clinical stage)		990	
AJCC ID	(01/01/2018)	995	D
AJCC TNM clin T	(01/01/2018)	1001	R*
AJCC TNM clin N	(01/01/2018)	1002	R*
AJCC TNM clin M	(01/01/2018)	1003	R*
AJCC TNM clin stage group	(01/01/2018)	1004	R*
AJCC TNM path T	(01/01/2018)	1011	R*
AJCC TNM path N	(01/01/2018)	1012	R*
AJCC TNM path M	(01/01/2018)	1013	R*
AJCC TNM path stage group	(01/01/2018)	1014	R*
AJCC TNM post therapy T	(01/01/2018)	1021	R*
AJCC TNM post therapy N	(01/01/2018)	1022	R*
AJCC TNM post therapy M	(01/01/2018)	1023	R*
AJCC TNM post therapy stage group	(01/01/2018)	1024	R*
AJCC TNM clin T suffix	(01/01/2018)	1031	R*
AJCC TNM path T suffix	(01/01/2018)	1032	R*
AJCC TNM post therapy suffix	(01/01/2018)	1033	R*
AJCC TNM clin N suffix	(01/01/2018)	1034	R*

ITEM	(Date Implemented)	NAACCR ITEM #	STATUS
AJCC TNM path N suffix	(01/01/2018)	1035	R*
AJCC TNM post therapy N suffix	(01/01/2018)	1036	R*
TNM edition number	(RH 01/01/2014 - 12/31/2017 & R* 01/01/2018)	1060	RH & R*
Mets at diagnosis - bone	(01/01/2016)	1112	R
Mets at diagnosis - brain	(01/01/2016)	1113	R
Mets at diagnosis - distant lymph nodes	(01/01/2016)	1114	R
Mets at diagnosis - liver	(01/01/2016)	1115	R
Mets at diagnosis - lung	(01/01/2016)	1116	R
Mets at diagnosis - other	(01/01/2016)	1117	R
SSDI: PTLD	(01/01/2025)	1172	R
SSDI: PD-L1	(01/01/2025)	1174	R
Lymphovascular Invasion	(01/01/2012)	1182	R
Date of surgical procedure of primary site (CoC item: Date of first surgical procedure)		1200	R
Date of surgical procedure flag	(01/01/2010-12/31/2022)	1201	R
Date radiation started		1210	R
Date radiation started flag	(01/01/2010-12/31/2022)	1211	R
Date chemotherapy started		1220	R
Date chemotherapy flag	(01/01/2010-12/31/2022)	1221	R
Date hormone therapy started		1230	R
Date hormone therapy flag	(01/01/2010-12/31/2022)	1231	R
Date immunotherapy (BRM) started		1240	R
Date immunotherapy (BRM) flag	(01/01/2010-12/31/2022)	1241	R
Date other treatment started		1250	R
Date other treatment flag	(01/01/2010-12/31/2022)	1251	R
Date of first course of treatment		1270	R
Date of first course of treatment flag	(01/01/2010-12/31/2022)	1271	R
Date of surgical dx/staging procedure (not NPCR-required)		1280	R
Date of dx/staging procedure flag (not NPCR-required)	(01/01/2010-12/31/2022)	1281	R
Treatment status	(01/01/2010)	1285	R
Surgical procedure of primary site	(01/01/1997-12/31/2022)	1290	R
RX Summ—Surg Prim Site 2023 (SEER/CoC)	(01/01/2023)	1291	RS
Scope of regional lymph node surgery		1292	R
Surgical procedure/other site		1294	R
RX Summ-Recon Breast	(01/01/2018)	1335	O
Reason for no surgery of primary site		1340	R
Surgical diagnostic & staging procedure (not NPCR-required)		1350	R
Radiation treatment summary	(Cases diagnosed through 2017)	1360	RH
Radiation/surgery sequence		1380	R
Chemotherapy		1390	R
Hormone therapy		1400	R
Immunotherapy (BRM)		1410	R

ITEM (Date Implemented)	NAACCR ITEM #	STATUS
Other treatment	1420	R
Reason for no radiation (01/01/2011)	1430	R
RX coding system current	1460	R
Phase I radiation external beam planning technique (01/01/2018)	1502	R
Phase I radiation treatment modality (01/01/2018)	1506	R
Regional radiation treatment modality (Cases diagnosed through 2017)	1570	RH
RX summ- -systemic/surgery sequence	1639	R
Date of last contact or death	1750	R
Date of last contact flag (01/01/2010)	1751	R
Vital status	1760	R
Cancer status (not NPCR-required)	1770	R
Follow-up source	1790	R*
Follow-up source central - for State use only	1791	R
Cause of death (Updated by Death Clearance procedures)	1910	R
ICD revision number (for cause of death)	1920	R
Place of death (Upd by Death Clearance procedures) (01/01/2013-12/31/2023)	1940	RH
Place of death – State (Upd by Death Clearance procedures) (01/01/2013)	1942	R
Place of death – Country (Upd by Death Clearance procedures) (01/01/2013)	1944	R*
Over-ride Site/TNM-StgGrp (01/01/2015)	1989	R
Over-ride Age/Site/Morph	1990	R
Over-ride TNM Stage	1992	R
Over-ride TNM Tis	1993	R
Over-ride SeqNo/DxConf	2000	R
Over-ride Site/Lat/SeqNo	2010	R
Over-ride Surg/DxConf	2020	R
Over-ride – Site/Type	2030	R
Over-ride Histology	2040	R
Over-ride Report Source	2050	R
Over-ride Ill-define Site	2060	R
Over-ride Leuk/Lymphoma	2070	R
Over-ride Site/Behavior	2071	R
Over-ride Site/Lat/Morph	2074	R
Over-ride Name/Sex	2078	R
Date case report exported	2110	R
Date case report received (stamp date) - for State use only	2111	R
Date case report loaded - for State use only	2112	R
Date tumor record available - for State use only	2113	R
ICD-O-3 conversion	2116	R
CoC accredited flag - for State use only	2152	R
Last name	2230	R
Birth surname (if applicable and available) (01/01/2021)	2232	R
First name	2240	R
Middle name	2250	R

ITEM (Date Implemented)		NAACCR ITEM #	STATUS
Alias		2280	R
Medical record number		2300	R
Medicare Beneficiary Identifier (NAACCR)		2315	R*
Social Security number		2320	R
Patient address (number and street) at diagnosis		2330	R
Patient address at diagnosis – supplemental		2335	R
Latitude - for State use only		2352	R*
Longitude - for State use only		2354	R*
DC state file number - for State use only		2380	R
Maiden name (if applicable and available)	(through 12/31/2020)	2390	RH
NPI-Institution referred from (not NPCR required)		2415	R
NPI-Institution referred to (not NPCR required)		2425	R
History and physical (text)		2520	R^
Dx procedures x-ray/scan (text)		2530	R^
Diagnostic scope procedures (text)		2540	R^
Dx procedures lab tests (text)		2550	R^
Surgical staging procedures (text)		2560	R^
Dx procedure pathology (text)		2570	R^
Primary site title (text)		2580	R^
Histology title (text)		2590	R^
Substantiate stage (text)		2600	R^
Surgical procedures (text)		2610	R^
Radiation beam (text)		2620	R^
Radiation other (text)		2630	R^
Chemotherapy (text)		2640	R^
Hormone (text)		2650	R^
Immunotherapy/BRM (text)		2660	R^
Other therapy (text)		2670	R^
Remarks		2680	O
CS tumor size	(01/01/2004 – 12/31/2015)	2800	RH
CS extension	(01/01/2004 – 12/31/2015)	2810	RH
CS tumor size/ext eval	(01/01/2008 – 12/31/2015)	2820	RH
CS lymph nodes	(01/01/2004 – 12/31/2015)	2830	RH
CS reg nodes eval	(01/01/2011 – 12/31/2015)	2840	RH
CS mets at dx	(01/01/2004 – 12/31/2015)	2850	RH
CS mets at diagnosis – bone	(01/01/2010 – 12/31/2015)	2851	RH
CS mets at diagnosis – brain	(01/01/2010 – 12/31/2015)	2852	RH
CS mets at diagnosis – liver	(01/01/2010 – 12/31/2015)	2853	RH
CS mets at diagnosis – lung	(01/01/2010 – 12/31/2015)	2854	RH
CS mets eval	(01/01/2011 – 12/31/2015)	2860	RH
CS site-specific factor 7	(01/01/2010 – 12/31/2015)	2861	RS/RH
CS site-specific factor 8	(01/01/2010 – 12/31/2017)	2862	RS/RH
CS site-specific factor 9	(01/01/2010 – 12/31/2017)	2863	RS/RH

ITEM	(Date Implemented)	NAACCR ITEM #	STATUS
CS site-specific factor 10	(01/01/2010 – 12/31/2017)	2864	RS/RH
CS site-specific factor 11	(01/01/2010 – 12/31/2017)	2865	RS/RH
CS site-specific factor 12	(01/01/2010 – 12/31/2015)	2866	RS/RH
CS site-specific factor 13	(01/01/2010 – 12/31/2017)	2867	RS/RH
CS site-specific factor 14	(01/01/2010 – 12/31/2017)	2868	RS/RH
CS site-specific factor 15	(01/01/2011 – 12/31/2017)	2869	RS/RH
CS site-specific factor 16	(01/01/2011 – 12/31/2017)	2870	RS/RH
CS site-specific factor 17	(01/01/2011 – 12/31/2015)	2871	RS/RH
CS site-specific factor 18	(01/01/2011 – 12/31/2015)	2872	
CS site-specific factor 19	(01/01/2011 – 12/31/2015)	2873	
CS site-specific factor 20	(01/01/2011 – 12/31/2015)	2874	
CS site-specific factor 21	(01/01/2011 – 12/31/2015)	2875	
CS site-specific factor 22	(01/01/2011 – 12/31/2015)	2876	
CS site-specific factor 23	(01/01/2011 – 12/31/2015)	2877	
CS site-specific factor 24	(01/01/2011 – 12/31/2015)	2878	
CS site-specific factor 25	(01/01/2010 – 12/31/2017)	2879	RS/RH
CS site-specific factor 1	(discontinued after 12/31/2017)	2880	RS/RH
CS site-specific factor 2	(discontinued after 12/31/2017)	2890	RS/RH
CS site-specific factor 3	(discontinued after 12/31/2015)	2900	RS/RH
CS site-specific factor 4	(01/01/2011 – 12/31/2015)	2910	RS/RH
CS site-specific factor 5	(01/01/2011 – 12/31/2017)	2920	RS/RH
CS site-specific factor 6	(01/01/2011 – 12/31/2017)	2930	RS/RH
CS version input original (autocoded)		2935	RS/RH
CS version derived (autocoded)		2936	RS/RH
CS version input current	(01/01/2010)	2937	RS/RH
Derived AJCC-6 T (autocoded)		2940	
Derived AJCC-6 T descriptor (autocoded)		2950	
Derived AJCC-6 N (autocoded)		2960	
Derived AJCC-6 N descriptor (autocoded)		2970	
Derived AJCC-6 M (autocoded)		2980	
Derived AJCC-6 M descriptor (autocoded)		2990	
Derived AJCC-6 stage group (autocoded)		3000	
Derived SS1977 (autocoded)	(01/01/2004 – 12/31/2015)	3010	
Derived SS2000 (autocoded)	(01/01/2004 – 12/31/2015)	3020	RH
Date of most definitive surgical resection of the primary site	(01/01/2015)	3170	R
Date of most definitive surgery flag	(01/01/2010-12/31/2022)	3171	R
Date systemic therapy started		3230	R
Date systemic therapy flag	(01/01/2010-12/31/2022)	3231	R
Hematologic transplant and endocrine procedures		3250	R
RuralUrban Continuum 2013 (Derived)	(01/01/2016)	3312	D
Derived AJCC-7 T (autocoded)	(01/01/2010 – 12/31/2015)	3400	RH
Derived AJCC-7 T descriptor (autocoded)	(01/01/2010 – 12/31/2015)	3402	RH
Derived AJCC-7 N (autocoded)	(01/01/2010 – 12/31/2015)	3410	RH

ITEM	(Date Implemented)	NAACCR ITEM #	STATUS
Derived AJCC-7 N descriptor (autocoded)	(01/01/2010 – 12/31/2015)	3412	RH
Derived AJCC-7 M (autocoded) (autocoded)	(01/01/2010 – 12/31/2015)	3420	RH
Derived AJCC-7 M descriptor (autocoded)	(01/01/2010 – 12/31/2015)	3422	RH
Derived AJCC-7 stage group (autocoded)	(01/01/2010 – 12/31/2015)	3430	RH
NPCR Derived Clin Stg Grp - for State use only	(01/01/2016 – 12/31/2017)	3650	RH
NPCR Derived Path Stg Grp - for State use only	(01/01/2016 - 12/31/2017)	3655	RH
SEER Site-Specific Fact 1	(01/01/2018)	3700	O
NPCR Specific Field - for State use only	(01/01/2014)	3720	R
Over-ride CS 1	(01/01/2012 – 12/31/2015)	3750	RH
Over-ride CS 2	(01/01/2012 – 12/31/2015)	3751	RH
Over-ride CS 3	(01/01/2012 – 12/31/2015)	3752	RH
Over-ride CS 4	(01/01/2012 – 12/31/2015)	3753	RH
Over-ride CS 5	(01/01/2012 – 12/31/2015)	3754	RH
Over-ride CS 6	(01/01/2012 – 12/31/2015)	3755	RH
Over-ride CS 7	(01/01/2012 – 12/31/2015)	3756	RH
Over-ride CS 8	(01/01/2012 – 12/31/2015)	3757	RH
Over-ride CS 9	(01/01/2012 – 12/31/2015)	3758	RH
Over-ride CS 10	(01/01/2012 – 12/31/2015)	3759	RH
Over-ride CS 11	(01/01/2012 – 12/31/2015)	3760	RH
Over-ride CS 12	(01/01/2012 – 12/31/2015)	3761	RH
Over-ride CS 13	(01/01/2012 – 12/31/2015)	3762	RH
Over-ride CS 14	(01/01/2012 – 12/31/2015)	3763	RH
Over-ride CS 15	(01/01/2012 – 12/31/2015)	3764	RH
Over-ride CS 16	(01/01/2012 – 12/31/2015)	3765	RH
Over-ride CS 17	(01/01/2012 – 12/31/2015)	3766	RH
Over-ride CS 18	(01/01/2012 – 12/31/2015)	3767	RH
Over-ride CS 19	(01/01/2012 – 12/31/2015)	3768	RH
Over-ride CS 20	(01/01/2012 – 12/31/2015)	3769	RH
Schema ID	(01/01/2018)	3800	D
Brain Molecular Markers	(01/01/2018)	3816	RS
P16	(Cervix 01/01/2021, Anus 01/01/2022, Vulva 01/01/2024)	3956	RS
Brain Primary Tumor Location	(01/01/2024)	3964	RS
Site-Specific Data Items (SSDI) Miscellaneous #'s 3801-3937	(01/01/2018)	misc.	RS
Site-Specific Data Items (SSDI) Miscellaneous #'s 3956	(01/01/2022)	misc.	RS
Site-Specific Data Items (SSDI) Miscellaneous #'s 3960	(01/01/2023)	misc.	RS

REPORTING FACILITY ID NUMBER

NAACCR Item #40

Item Length: 3
Data Type: Numeric
ACoS: Required
State Registry: Required

Description
This is a required 3-character field for recording a unique 3-digit identification number assigned to each reporting facility in Indiana.

The Facility ID number identifies the facility reporting the case. It also allows the State Registry to collect information from multiple facilities that have seen the same patient for the same tumor. In the State Cancer Registry database, up to ten different facility ID numbers can be recorded for each tumor. Each of the ten facilities can be listed with its admission date, accession year and number, medical record number, and class of case for that tumor.

Instruction
Referring to Appendix D, enter your 3-digit facility ID number in this field.

NPI-REPORTING FACILITY

NAACCR Item #545

Item Length: 10
Data Type: Numeric
ACoS: Required
State Registry: Required

Description
This is a required 10-character field that identifies the facility submitting the data in the record. NPI (National Provider Identifier) is a unique identification number for health care providers implemented by the Centers for Medicare & Medicaid Services as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Rationale
Each facility's NPI is unique. The number is essential to National Cancer Database (NCDB) for monitoring data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

Codes
NPI numbers for Indiana facilities are provided in Appendix D of this manual.

Instructions
a. *NPI-Reporting Facility* is automatically coded by the software provider.

b. NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008.

c. NPI may be blank for cases diagnosed on or before December 31, 2006.

ABSTRACTED BY

Item Length: 3
Data Type: Alphanumeric
Left Justified, Blank Fill
ACoS: Required
State Registry: Required

NAACCR Item #570

Description
This is a required 3-character field to record the initials or assigned code of the individual who abstracted the case.

Rationale
This item is most useful for multi-staffed registries and can be used for quality control and management.

Instructions
a. Record the initials or assigned code of the individual who abstracted this case. If the initials are less than three characters, left justify and blank fill.

b. Do not code the data entry person unless that person is also the abstractor.

Instructions for WebPlus
a. The initials will automatically be entered in each abstract based on the identification used to log in.

b. The initials automatically entered may be manually changed if a second abstracter completes a case in a session logged in by someone else.

TYPE OF REPORTING SOURCE

Item Length: 1
Data Type: Numeric
ACoS: N/A
State Registry: Required

NAACCR Item #500

Data item revised for cases diagnosed 01/01/2006 and later.

Description
This is a required 1-character field for coding the source documents used to abstract the majority of information for the tumor being reported. The item is intended to indicate the completeness of information available to the abstractor.

Rationale
The code in this field can be used to explain why information for a tumor may be incomplete. For example, death certificate only cases have unknown values for many data items, so one may want 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 casefinding and that follow-back to uncover missed hospital reports was not complete.

Codes *(effective for cases diagnosed 01/01/2006 and later)*
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 (diagnosed at autopsy)
7 Death certificate only
8 Other hospital outpatient units/surgery centers

Notes:
a. 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 (for cases diagnosed 01/01/2006 and later) and to prioritize laboratory reports over nursing home reports. Facilities previously defined under code 1 have been split between codes 1, 2, and 8.

b. Use the code that reflects the source documents used to abstract the majority of information for 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, record code 4.

Definitions
a. **Code 1** includes hospitals as well as specified managed health plans. Reports from health plans (e.g., Kaiser, Veterans Administration, military facilities), in which all diagnostic and treatment information is maintained centrally and available to the abstractor, are expected to be at least as complete as reports for hospital inpatients. Therefore, these sources are grouped with inpatients and given the code with the highest priority.

b. **Code 2** includes (radiation or medical) cancer treatment facilities, whether they are affiliated with a hospital or not. These sources usually have complete information on the cancer diagnosis, staging, and treatment.

c. **Code 3** is generally for use by independent pathology laboratories. If a hospital's pathology department has a report on a non-hospital case (with no inpatient or outpatient record) and no other information is available, code 3 should be used. For example, a hospital that finds a reportable case by reviewing pathology reports should report the case as Reporting Source 3 if no other records or information were available. This might happen if an outside physician contracted to use the hospital's pathology laboratory facilities.

d. **Code 4** includes physician offices as well as independent, freestanding clinics with no hospital affiliation and that are not defined under Code 2. Examples of these may include surgery centers with no hospital affiliation and HMOs.

e. **Codes 6 and 7** are used only when investigation can find no clinical diagnosis of any kind while the patient was alive.

f. **Code 8** sources would include, but would not be limited to, hospital 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 and staffed 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.

SUSPENSE CASE

Item Length: 1
Data Type: Numeric
ACoS: N/A
State Registry: Retired Field 1/1/2025

Description
Records identified as incomplete will be bypassed when normal edits are applied. A suspense system can be created using this field by printing a suspense list of the incomplete cases.

The paper Hospital Abstract does not include this field, since the suspense system for paper abstractors is created by a separate filing of the abstracts or by using index cards. *ISCR will no longer accept paper abstracts beginning 1/1/2026

Facilities using other vendors' registry programs should follow the applicable vendor's instructions for suspense cases.

Codes
1 Partial record (suspense, premalignant, incomplete)
0 Complete record

Instructions
a. Record a 1 in the suspense field for cases that have not been completely abstracted.

b. When the record is completely abstracted, change the code and apply edits to the record.

c. Refer to Chapter 2, Section D for requirements related to suspense systems.

PATIENT LAST NAME

Item Length: 40
Data Type: Alphabetic
Left Justified, Blank Fill
ACoS: Required
State Registry: Required

NAACCR Item #2230

Description
This is a required 40-character field for the patient's last name. Left justify and leave unused space(s) at the right blank.

Instructions
a. In a hyphenated last name, record the hyphen (-) between the two surnames (last names). This might happen when a female marries and keeps her maiden name as part of her legal married name.

   Example: SMITH-WALBRIDGE

b. Do not enter periods, apostrophes, blank spaces, punctuation, or other special characters (e.g., Jr, III) within the name.

   Example 1: OHARA (NOT O'HARA)
   Example 2: MCDONALD (NOT MC DONALD*)*
   Example 3: STPIERRE (NOT ST. PIERRE OR SAINT PIERRE)

   Note: The 2018 *STORE* allows blanks, spaces, and apostrophes in the last name field. However, changing the name format at this point would compromise the linking or matching of new cases with cases previously entered in the registry. Therefore, it is advisable to continue following the old formatting rules.

c. Update the field if a patient changes his/her last name. If a patient changes his/her legal name, enter the patient's most current legal name and put previous last name in the field for birth surname. If a patient has more than one tumor, previous records with different last names (AKA's) should be updated to show the most recent name change. The old name should be recorded in *Birth Surname*.

   Example: Jane White, who had a primary in 2017, marries in 2018 and becomes Jane Black. In 2021 she has a second primary. Change the last name in the 2017 abstract from White to Black and record White in *Birth Surname*. Record the same names for the 2021 primary: Black (White in *Birth Surname*).

d. Do not leave the field blank. If the patient's last name is unknown, record UNKNOWN.

PATIENT FIRST NAME

Item Length: 40
Data Type: Alphabetic
Left Justified, Blank Fill
ACoS: Required
State Registry: Required

NAACCR Item #2240

Description
This is a required 40-character field for the patient's first name. Left justify and leave unused space(s) at the right blank.

Instructions
a. Record the patient's full first name.

b. If the first name is not known, leave the field blank.

PATIENT MIDDLE NAME (MIDDLE INITIAL)

NAACCR Item #2250

Item Length: 40
Data Type: Alphabetic
Left Justified, Blank Fill
ACoS: Required
State Registry: Required

Description
This is a required 40-character field for the patient's middle name or middle initial. Left justify and leave unused space(s) at the right blank.

Instructions
a. Record the patient's middle name or middle initial. If recording only a middle initial, do not enter a period after the letter.

b. If the middle name is not known, leave the field blank.

BIRTH SURNAME

Item Length: 40
Data Type: Alphabetic
Left Justified, Blank Fill
ACoS: N/A
State Registry: *Required

NAACCR Item #2232

*Required if available for cases diagnosed 01/01/2021 and later.

Description
This is a required 40-character field for the last name of the patient at birth regardless of gender or marital status. It is a replacement for the data item *Name – Maiden.* Left justify and leave unused space(s) at the right blank.

Instructions
a. Truncate the name if longer than 40 characters.

b. Leave the field blank if the birth surname is not known or not applicable.

c. Do not enter periods, apostrophes, blank spaces, punctuation, or other special characters (e.g., Jr, III) within the name. See instructions for *Patient Last Name* that describe the reason for maintaining this rule.

Example 1: OHARA (NOT O'HARA)
Example 2: MCDONALD (NOT MC DONALD)
Example 3: STPIERRE (NOT ST. PIERRE OR SAINT PIERRE)

PATIENT ALIAS

Item Length: 40
Data Type: Alphabetic
Left Justified, Blank Fill
ACoS: N/A
State Registry: *Required

NAACCR Item #2280

*Required if available for cases diagnosed 01/01/2006 and later.

Description
This is an optional 40-character field to record the alias, if the patient uses a different name or nickname. Left justify and leave unused space(s) at the right blank.

Instructions
a. First name only alias
If the patient uses an alias for a first name only, record the actual last name and the first name alias. In the WebPlus abstract screen, leave a blank space, without punctuation, between the last and first names.

Example: Ralph Williams uses the name Bud Williams. Record Williams Bud.

b. Last name only alias
If the patient uses only a last name alias, record the last name alias and the actual first name. In the WebPlus abstract screen, leave a blank space, without punctuation, between the last and first names.

Example: Janice Smith uses the name Janice Brown. Record Brown Janice.

c. Alias first and last name
If the patient uses an alias for the first and last name, record the last name alias and the first name alias. In the WebPlus abstract screen, leave a blank space, without punctuation, between the last and first names.

Example: Samuel Clemens uses the name Mark Twain. Record Twain Mark.

d. If the patient does not use an alias, leave the field blank.

GENERAL GUIDELINES FOR RECORDING PATIENT ADDRESS AT DIAGNOSIS

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

Rules and Definitions: Use the following guidelines for all patient address data items.

a. Record the patient's usual residence when the cancer was diagnosed. Normally a residence is the home named by the patient. Do not use a temporary address, such as a winter or vacation home. Legal status and citizenship are not factors in residency decisions. Rules of residency are identical to or comparable with rules used by the Census Bureau whenever possible. The registry can resolve residency questions by using the Census Bureau's definition: "The place where he or she lives and sleeps most of the time or the place the person considers to be his or her usual home." Vital statistics rules may differ from census rules. Do not record residence from the death certificate. Review each case carefully and apply the rules.

b. Do not use current address. Record the address for the patient's home when he/she was diagnosed with cancer for both analytic and nonanalytic cases. If all or any part of the address is unknown, follow the instructions for unknowns under the applicable item heading in the following pages.

c. Rules for persons without apparent residences:

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

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

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

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

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

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

The Census Bureau has detailed residency rules for Naval personnel, Coast Guard, and maritime ships. Refer to Census Bureau publications for the detailed rules.

Patient Address – Current
The State Registry does not collect the patient's current address, although there are separate fields in the WebPlus program for recording it.

PATIENT ADDRESS (NUMBER AND STREET) AT DIAGNOSIS

Item Length: 60
Data Type: Alphanumeric
Left Justified, Blank Fill
ACoS: Required
State Registry: Required

NAACCR Item #2330

Description
This is a required 60-character field for the patient's house number and street address at the time of diagnosis. Enter the house number and street name or the rural mailing address. This may or may not be the patient's current address. If the patient has multiple tumors, the address may be different for each primary. See "General Guidelines for Recording Patient Address at Diagnosis" for detailed residency rules.

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

Instructions
a. Record the number and street address of the patient's usual residence when the cancer was diagnosed. Do **not** record a post office box number unless it is the only address available.

b. Avoid using punctuation, except when necessary to convey the meaning. Limit punctuation to periods when the period carries meaning (e.g., 39.2 RD), slashes for fractional addresses (e.g., 101 1/2 MAIN ST), and hyphens when the hyphen carries meaning (e.g., 289-01 MONTGOMERY AVE). Avoid using the pound sign (#) to designate address units whenever possible. If a pound sign is used, there must be a space between the pound sign and the secondary number.

c. Do not update this data item if the patient's address changes.

d. Use standard abbreviations recognized by the U.S. Postal Service (USPS). The USPS Postal Addressing Standards, Pub 28, November 2000 can be found on the Internet at *http://pe.usps.com/text/pub28/welcome.htm*. Standard abbreviations include, but are not limited to:

Apartment	APT	Rural Route	RR
Avenue	AVE	State Road	SR
Boulevard	BLVD	Street	ST
Building	BLDG	Suite	STE
Circle	CIR	Terrace	TER
Court	CT	Unit	UNIT
Department	DEPT		
Drive	DR	North	N
Floor	FL	Northeast	NE
Lane	LN	Northwest	NW
Parkway	PKY	South	S
Place	PL	Southeast	SE
Post Office	PO	Southwest	SW
Road	RD	East	E
Room	RM	West	W

Example 1: 123 MAIN ST APT 5
Example 2: RR 2 BOX 421
Example 3: 103 FIRST AVE SW APT 102

e. If the number and street address at diagnosis is not known, enter "UNKNOWN" in this field.

PATIENT ADDRESS (NUMBER AND STREET) AT DIAGNOSIS – SUPPLEMENTAL

Item Length: 60
Data Type: Alphanumeric
Left Justified, Blank Fill
ACoS: Required
State Registry: *Required

NAACCR Item #2335

*Required if available for cases diagnosed 01/01/2006 and later.

Description
This item provides the ability to store additional address information, such as the name of a place or facility (e.g., 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
a. Record the place or facility (e.g., a nursing home or name of an apartment complex) of the patient's usual residence when the tumor was diagnosed.

b. Do **not** record apartment number, lot number, or other such information in this item. Record this information in the street address line.

c. If the patient has multiple tumors, the address may be different for subsequent primaries.

d. Do not update this data item if the patient's address changes.

e. If this address space is not needed, leave the item blank.

CITY/TOWN AT DIAGNOSIS

Item Length: 50
Data Type: Alphabetic
Left Justified, Blank Fill
ACoS: Required
State Registry: Required

NAACCR Item #70

Description
This is a required 50-character field for the patient's usual city or town at the time of diagnosis. If the patient has multiple tumors, the address may be different for each primary. See "General Guidelines for Recording Patient Address at Diagnosis" for detailed residency rules.

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

Instructions
a. Record the city or town of the patient's usual residence when the cancer was diagnosed.

b. Do not use punctuation or special characters and abbreviate when necessary.

c. Do not update this data item if the patient's city/town of residence changes.

d. If the city is not known, enter "UNKNOWN."

STATE AT DIAGNOSIS

NAACCR Item #80

Item Length: 2
Data Type: Alphabetic
ACoS: Required
State Registry: Required

Item revised for cases diagnosed 01/01/2007 and later.

Description
This is a required 2-character field for the patient's usual state of residence at the time of diagnosis. See "General Guidelines for Recording Patient Address at Diagnosis" for detailed residency rules.

Rationale
The address is a 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
a. Record the standard U.S. Postal Service 2-letter abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province/territory in which the patient resides at the time of diagnosis. The 2-letter codes appear on the following page.

b. If the patient has multiple tumors, the state of residence may be different for each primary.

c. Do not update this data item if the patient's state of residence changes.

Special Codes
CD Resident of Canada, NOS (province/territory unknown)

US Resident of United States, NOS (state/commonwealth/territory/possession unknown)

XX Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is known. Code the country of residence in *County at Diagnosis*.

YY Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is unknown.

ZZ Residence unknown

State Abbreviation Codes

STATE		STATE		STATE	
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	**OTHER**	
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	SC	APO/FPO Armed Services Europe	AE
Maryland	MD	South Dakota	SD	APO/FPO Armed Services Pacific	AP

Abbreviation Codes for Canadian Provinces and Territories

PROVINCE		PROVINCE	
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		

POSTAL CODE (ZIP CODE) AT DIAGNOSIS

Item Length: 9
Data Type: Numeric
Left Justified, Blank Fill
ACoS: Required
State Registry: Required

NAACCR Item #100

Description
This is a required 9-character field for the patient's postal (ZIP) code at the time of diagnosis. The 4-digit extension is optional. See "General Guidelines for Recording Patient Address at Diagnosis" for detailed residency rules.

Rationale
The address is a 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
a. For U.S. residents record the U.S. Postal Service ZIP code for the patient's residence at the time of diagnosis.

b. The ZIP code field in the WebPlus program will accept the "ZIP plus 4" extended ZIP code. Do not enter a dash before the 4-digit extension.

   Recording the 4-digit extension is optional. If the 4-digit extension is not recorded, left justify the 5-digit code and leave the remaining spaces blank.

c. For residents of Canada and Puerto Rico record the postal code, left justify, and leave the remaining spaces blank.

d. If the patient has multiple malignancies, the postal code may be different for each primary.

e. Do not update this data item if the patient's postal code changes.

Special Codes
88888 Permanent address in a country other than Canada, United States, or US possession and postal code is unknown.
99999 Permanent address in Canada, United States, or US possession and postal code is unknown.

COUNTY AT DIAGNOSIS

NAACCR Item #90

Item Length: 3
Data Type: Numeric
Right Justified, Blank Fill
ACoS: Required
State Registry: Required

Description
This is a required 3-character field to record the county of the patient's usual residence at the time of diagnosis. See "General Guidelines for Recording Patient Address at Diagnosis" for detailed residency rules.

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

Codes
Use the codes issued by the Bureau of Standards in the Federal Information Processing Standards (FIPS). FIPS codes for Indiana counties are listed on the following page.

Instructions
a. Residents of Indiana
For Indiana Residents, enter the 3-digit FIPS code for the patient's county of residence at the time of diagnosis from the list on the following page.

b. Residents of States Other than Indiana
(1) If the patient is a resident of a state other than Indiana, and your facility does not collect identification codes for counties of that state, record the 998 code defined under "special codes."

(2) If the patient is a resident of a state other than Indiana, and your facility collects identification codes for counties of that state, use the FIPS codes for that state. Appendix H lists the FIPS codes for counties in the states adjoining Indiana. If you need codes for states other than those provided, contact the State Registry.

c. Residents of Countries other than the United States
If the patient is a resident of a country other than the United States, record the code for the country in this field. An XX code would have been recorded in *State at Diagnosis*.

For country codes, see one of the following:
- *The SEER Program Coding and Staging Manual*, Appendix B at http://seer.cancer.gov/tools/codingmanuals/
- *STORE* Appendix C at Link.

d. Do not update this data item if the patient's county of residence changes.

Special Codes
998 The patient resides outside of the state of the reporting facility.
999 Unknown county/country. The patient is a resident of Indiana but the address is unknown.

INDIANA COUNTY CODES

FIPS	County	FIPS	County	FIPS	County
001	Adams	**071**	Jackson	**141**	St. Joseph
003	Allen	**073**	Jasper	**143**	Scott
005	Bartholomew	**075**	Jay	**145**	Shelby
007	Benton	**077**	Jefferson	**147**	Spencer
009	Blackford	**079**	Jennings	**149**	Starke
011	Boone	**081**	Johnson	**151**	Steuben
013	Brown	**083**	Knox	**153**	Sullivan
015	Carroll	**085**	Kosciusko	**155**	Switzerland
017	Cass	**087**	LaGrange	**157**	Tippecanoe
019	Clark	**089**	Lake	**159**	Tipton
021	Clay	**091**	LaPorte	**161**	Union
023	Clinton	**093**	Lawrence	**163**	Vanderburgh
025	Crawford	**095**	Madison	**165**	Vermillion
027	Daviess	**097**	Marion	**167**	Vigo
029	Dearborn	**099**	Marshall	**169**	Wabash
031	Decatur	**101**	Martin	**171**	Warren
033	DeKalb	**103**	Miami	**173**	Warrick
035	Delaware	**105**	Monroe	**175**	Washington
037	Dubois	**107**	Montgomery	**177**	Wayne
039	Elkhart	**109**	Morgan	**179**	Wells
041	Fayette	**111**	Newton	**181**	White
043	Floyd	**113**	Noble	**183**	Whitley
045	Fountain	**115**	Ohio		
047	Franklin	**117**	Orange		
049	Fulton	**119**	Owen		
051	Gibson	**121**	Parke		
053	Grant	**123**	Perry		
055	Greene	**125**	Pike		
057	Hamilton	**127**	Porter		
059	Hancock	**129**	Posey		
061	Harrison	**131**	Pulaski		
063	Hendricks	**133**	Putnam		
065	Henry	**135**	Randolph		
067	Howard	**137**	Ripley		
069	Huntington	**139**	Rush		

CENSUS TRACT 2000

Item Length: 6
Data Type: Numeric
Zero Fill
ACoS: N/A
State Registry: Required*

NAACCR Item #130

*Completed by the State Registry

Description
This is a required 6-character field for recording a census tract code that identifies the patient's residence at time of diagnosis. The code pinpoints residence at diagnosis within a geographic area smaller than the county of residence. Census tract is collected to meet the requirements of the Federal cancer registries grant.

Rationale
Census tract codes allow central registries to calculate incidence rates for geographical areas having population estimates. This field allows a central registry to add Year 2000 Census tract to cases diagnosed in previous years.

Definition
Census tract codes originate from the Bureau of the Census and are constructed using the patient's address. The boundaries of census tracts are established cooperatively by local committees and the Census Bureau. The corresponding population of the census tract area can be obtained from the Census Bureau. Codes are available from state health departments or the Bureau of the Census.

Instructions
a. The State Cancer Registry will code this item using computerized methods based on the patient's address at diagnosis. If your facility already collects census tract, please contact the State Registry to avoid unnecessary duplication of effort. The field is described here for general informational purposes.

b. When coding census tract, the decimal point is assumed to be between the fourth and fifth positions of the field. Zeros are added to fill all six positions.

Example 1: Census tract 409.6 (0409.60) would be coded 040960.
Example 2: Census tract 516.21 (0516.21) would be coded 051621.

Special Codes
000000 Area is not census tracted
999999 Area is census tracted, but census tract is not available
blank Census Tract 2000 not coded

CENSUS TRACT CERTAINTY 2000

Item Length: 1
Data Type: Numeric
ACoS: N/A
State Registry: Required

NAACCR Item #365

*Completed by the State Registry

Description
This is a required 1-character field in the abstract for recording the basis of assignment of census tract for an individual record. This item is not coded by the hospital. The information is usually provided by a geocoding vendor service, but may be manually assigned by central registry staff. The codes are hierarchical, with lower numbers having priority.

Rationale
This item is helpful in identifying cases tracked from incomplete information or P.O. Box.

Codes
1 Census tract based on complete and valid street address of residence
2 Census tract based on residence ZIP + 4
3 Census tract based on residence ZIP + 2
4 Census tract based on residence ZIP code only
5 Census tract based on ZIP code of P.O. Box
9 Unable to assign census tract or bloc numbering based on available information
blank Not applicable (e.g., census tracking not attempted); Census Tract Certainty information for 2000 not coded

Instructions
The State Cancer Registry will code this item using computerized methods based on the patient's address at diagnosis. The field is described here for general informational purposes.

SOCIAL SECURITY NUMBER

NAACCR Item #2320

Item Length: 9
Data Type: Numeric
ACoS: Required
State Registry: Required

Description
This is a required 9-character field to record the patient's Social Security Number (SSN).

Rationale
This item is extremely important in identifying, linking, and matching multiple records on the same patient and in differentiating patients with similar names at the State Cancer Registry. Every effort should be made to obtain the correct number for each patient.

Instructions
a. Do not enter any dashes, other punctuation, or any alphabetical letters.

b. Do not record Social Security numbers that end with B or D. These letters signify that the number is the spouse's and indicate that the patient is receiving benefits under the spouse's number. Code as 999999999.

c. You can assume the Medicare number is the Social Security number if it is prefixed with "A" or "C." Do not enter the prefix "A" or "C" on the abstract as part of the Social Security number. *(As of 1/1/2018, the social security number is no longer used on the Medicare A/B card, the Medicare Beneficiary Number replaced the social security number. Do not use this number unless on a social security card issued prior to 2018).*

Special Codes
999999999 The patient does not have a Social Security number, or it is not available or unknown. Do not leave the field blank.

DATE OF BIRTH

NAACCR Item #240

Item Length: 8
Data Type: Numeric
ACoS: Required
State Registry: Required

Description
This is a required 8-character field for recording the patient's birth date.

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

Codes

	Month	Day	Year
01	January	01	Use four-digit year (e.g., 1952)
02	February	02	blank = Year unknown
03	March	03	
04	April	...	
05	May	...	
06	June	25	
07	July	26	
08	August	...	
09	September	30	
10	October	31	
11	November	blank = Day unknown	
12	December		
blank	Month unknown		

Instructions

a. Record the patient's date of birth as documented in the patient record. Use the full four-digit year for year. Determine whether your software vendor uses the traditional format for date entry (MMDDCCYY) or the interoperable format (CCYYMMDD). The WebPlus program uses the traditional format.

b. For in utero diagnosis and treatment, record the actual date of birth. The date of birth will follow one or both dates for those events.

c. 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 spaces blank.

   Example:
   The patient is 60 years old when admitted to the hospital on June 15, 2001 and no birth date is given. Record _ _/_ _/1941 or 1941/_ _/_ _, depending on the date format your software uses. Leave the month and day spaces blank.

d. If month is unknown, the day is coded unknown. If the year cannot be determined, code day and month as unknown.

e. If the date of birth cannot be determined at all, leave the date of birth field blank and record the reason in *Date of Birth Flag*. See the *Date of Birth Flag* section for examples illustrating the relationships among these items. **(No longer applicable 1/1/2023, year of birth must be entered)**

DATE OF BIRTH FLAG

NAACCR Item #241

Item Length: 2
Data Type: Numeric
ACoS: Required
State Registry: Required

*Required if applicable for cases diagnosed 01/01/2015-12/31/2022

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of Birth* (NAACCR Item #240).

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

Codes
12 A valid date is applicable but not known (for example, birth date is unknown)
Blank A valid date is coded in the *Date of Birth* item (NAACCR Item #240).

Instructions
a. Leave this item blank if *Date of Birth* has a full or partial date recorded.
b. Use code 12 if the *Date of Birth* cannot be determined at all.
c. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

Examples:

Description	Date (Leave unknown portions blank.)	Date of Birth Flag
Full date known	*12/07/1953 or 1953/12/07	Blank
Month & year known	*12/_ _ /1953 or 1953/12/_ _	Blank
Year only known	*_ _/_ _/1953 or 1953/_ _/_ _	Blank
Unknown date	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	12

***** For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The WEBPLUS program uses the traditional format. The computer will store either in the interoperable format.

AGE AT DIAGNOSIS

Item Length: 3
Data Type: Numeric
Right Justified, Zero Fill
ACoS: Required
State Registry: Required

NAACCR Item #230

Description
This is a required 3-character field in the WEBPLUS abstract screen for recording patient age at the time of diagnosis. The patient's age at diagnosis is automatically calculated by the WEBPLUS program after the date of birth and date of diagnosis are recorded.

Definition
"Age at Diagnosis" is the patient's age at his or her last birthday before diagnosis.

Examples:
000 Less than one year old; diagnosed *in utero*
001 One year old, but less than two years old
002 Two years old
... Actual age in years
999 Unknown age

Instructions for Facilities Using WEBPLUS
a. If the date of birth and date of diagnosis are recorded, leave the item blank. The WEBPLUS software program will automatically calculate age.

b. If either the date of birth or the date of diagnosis is unknown, you may manually enter the age at diagnosis in the WEBPLUS program if you know or can estimate the patient's age, even without a birth date or diagnosis date.

PLACE OF BIRTH

NAACCR Item #250

Item Length: 3
ACoS: Required through 2012
State Registry: Required through 2012
(01/01/2013-12/31/2023)

*This item was coded for cases diagnosed through 2012 and should be converted automatically by the registry's software to the 2013 items, Birthplace – State and Birthplace – Country.

Description
This is a 3-character field in the WEBPLUS abstract screen for recording a numeric code that identifies the state or country (if outside the United States) of the patient's birth. The State Registry requires the item if the information is available.

Codes
Use SEER Geocodes for Place of Birth. See The SEER Program Code Manual, Revised Edition, (http://seer.cancer.gov/tools/codingmanuals/) or Standards for Cancer Registries Volume II: Data Standards and Data, (http://www.naaccr. org).

Special Codes
000 United States, NOS
998 Place of birth outside of the United States, no other detail known
999 Place of birth unknown

BIRTHPLACE - STATE

NAACCR Item #252

Item Length: 2
ACoS: Required
State Registry: Required if available

Description
This is a 2-character field for recording the patient's state of birth. The State Registry requires the item if the information is available.

Codes
See the table provided for *State at Diagnosis* for the list of state codes.

Special Codes
XX Born in a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is known (code the country in *Birthplace-Country)*
YY Born in a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is unknown
US Born in the U.S. (including its territories, commonwealths, or possessions) and the state is unknown
CD Born in Canada and the province is unknown.
ZZ Place of birth is unknown, not mentioned in the patient record

Note
This item was first defined for use in 2013. Cases diagnosed before 2013 should be converted automatically by the registry's software from the former *Place of Birth*.

BIRTHPLACE - COUNTRY

Item Length: 3
ACoS: Required
State Registry: Required if available

NAACCR Item #254

Description
This is a 3-character field for recording the country where the patient was born. The State Registry requires the item if the information is available.

Codes
For country codes, see one of the following:

- *The SEER Program Coding and Staging Manual*, Appendix B at http://seer.cancer.gov/tools/codingmanuals/
- *STORE Appendix C at https://www.facs.org/qualityprograms/cancer/ncdb/registrymanuals/cocmanuals*

Examples
USA United States
CAN Canada
ZZX Non-US NOS
ZZU Place of birth is unknown, not mentioned in patient record

Note
This item was first defined for use in 2013. Cases diagnosed before 2013 should be converted automatically by the registry's software from the former *Place of Birth*.

MEDICAL RECORD NUMBER

Item Length: 11
Data Type: Alphanumeric
Right Justified, Blank Fill
ACoS: Required
State Registry: Required

NAACCR Item #2300

Description
This is a required 11-character field to record the patient's medical record number. The medical record number is a patient identification number usually assigned by a hospital's medical record or health information management (HIM) department.

Instructions
a. If the number is less than 11 digits, right justify and leave the leading spaces blank.

Example: Medical record number 24937 should be entered as _ _ _ _ _ _ 24937.

Note (for facilities using WEBPLUS): The medical record number may be entered from the left (left justified). After the record is exited, the WEBPLUS program will automatically right justify the number.

b. Do not include any hyphens, dashes, slashes, or other punctuation.

c. If the hospital uses the patient's Social Security Number for the medical record number, record it in this field without dashes or spaces. Right justify and leave the leading spaces blank.

Special Codes

_ _ _ _ _ _ _ _ UNK	The patient's medical record number is unknown.
_ _ _ _ _ _ _ _ RT	Radiation therapy department patient without HIM medical record number
_ _ _ _ _ _ _ _ SU	One-day surgery clinic patient without HIM medical record number
blank	The patient does not have a medical record number at your hospital.

Note: Other standard abbreviations may be used to indicate departments within the facility for patients without HIM numbers.

MEDICARE BENEFICIARY IDENTIFIER

NAACCR Item #2315

Item Length: 11
Data Type: Alphanumeric
Right Justified, Blank Fill
ACoS: Required
State Registry: Required

*Required if available for diagnosis 01/01/2018 and forward

Description

Congress passed the Medicare Access and CHIP Reauthorization ACT to remove Social Security Number (SSN) from Medicare ID card and replace the existing Medicare Health Insurance Claim Numbers with a Medicare Beneficiary Identifier (MBI). The MBI will be a randomly generated identifier that will not include a SSN or any personal identifiable information

Rationale:
The MBI is a step to minimize the risk of identity theft for Medicare beneficiaries and reduce opportunities for fraud. In early 2018, CMB plans to issue new Medicare cards with an MBI. A Health Insurance Claim Number will still be assigned to each Medicare beneficiary and will still be used for internal data exchanges between CMS and the states, but the new MBI must be used in all interactions with the beneficiary, the provider community and all external partners. The collection of the MBI should not change how registries currently collect SSN.

Instructions:

a. Leave blank if not Medicare Part A/B insured at time of diagnosis
b. Enter alphanumeric identifier assigned to the patient only
c. Do not enter a policy/group number for Managed Medicare Plans

Note:

The Medicare Beneficiary Identifier (MBI) is randomly generated and has 11 characters, consisting of numbers and letters, entered without dashes. The MBI format: https://www.cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI-with-Format.pdf

SEX

NAACCR Item #220

Item Length: 1
Data Type: Numeric
ACoS: Required
State Registry: Required

Description
This is a required 1-character field to record a code that identifies the patient's sex.

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.

Codes
1 Male
2 Female
3 Other (hermaphrodite)
4 Transsexual, NOS
5 Transsexual, natal male
6 Transsexual, natal female
9 Not stated

Note: Codes 5 and 6 were added for 2015, but may be used for earlier diagnoses.

PRIMARY PAYER AT DIAGNOSIS

Item Length: 2
Data Type: Numeric
ACoS: Required
NAACCR Item #630
State Registry: *Required if available

*Required if available for cases diagnosed 01/01/2006 and later.

Description
This is a required 2-character field to identify 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. Joint Commission of Accreditation of Healthcare Organizations (JCAHO) 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.

Codes

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 described in the definitions for codes 20, 21, 31, 35, 60-68.
20	Private Insurance: Managed care, HMO, 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 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 those described in the definition for 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 65 years of age or older, or are chronically disabled (Social Security insurance eligible). Not described in the definitions for codes 61, 62, or 63.
61	Medicare with supplement, NOS	Patient has 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.
65	TRICARE	Department of Defense program providing supplementary civilian-sector hospital and medical services beyond a military treatment facility to military dependents, retirees, and their dependents. Formerly CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).

Code	Label	Definition
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 receives care at a Public Health Service facility or at another facility and 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.

Instructions

a. Record the applicable code from the above list for the type of insurance reported on the patient's admission page.

b. Codes 21 and 65-68 are to be used for patients diagnosed on or after January 1, 2006.

c. If more than one payer or insurance carrier is listed on the patient's admission page, record the first.

d. If the patient's payer or insurance carrier changes, do not change the initially recorded code.

Codes with Examples:

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.

RACE AND SPANISH ORIGIN
(RACE AND ETHNICITY)

NAACCR Item #s 160-164 (Race) and 190 (Ethnicity)

Item Length: 2 + 1
Data Type: Numeric
ACoS: Required
State Registry: Required

Description
This is a required 2-character field to record a code that identifies the patient's race and a required 1-character field to record a code for the patient's origin, if of Spanish/Hispanic descent.

Codes for Race
01 White
02 Black or African American
03 American Indian or Alaska Native
04 Chinese
05 Japanese
06 Filipino
07 Native Hawaiian
08 Korean
09 Asian Indian, Pakistani
10 Vietnamese
11 Laotian
12 Hmong
13 Cambodian
14 Thai
15 Asian Indian, NOS or Pakistani, NOS
20 Micronesian, NOS
21 Chamorro
22 Guamanian, NOS
25 Polynesian, NOS
26 Tahitian
27 Samoan
28 Tongan
30 Melanesian, NOS
31 Fiji Islander
32 Papua New Guinean
88 No further race documented (for Race 2-5 in cases diagnosed 01/01/2000 and later)
96 Other Asian, including Asian, NOS
97 Pacific Islander, NOS
98 Some other race
99 Unknown by patient

Codes 20-97 were adopted for use effective with 1991 diagnoses. Code 14 was adopted for use effective with 1994 and later cases.

Definitions
a. **Code 01** (white) includes Mexican, Puerto Rican, Cuban, and all other Caucasians.

b. **Code 02** (black) includes persons reported as African American, Afro-American, Negro, brown, or colored.

c. **Code 13** (Kampuchean) includes patients whose race is listed as Cambodian.

Instructions
a. Additional races reported by the person should be coded in *Race 2*, *Race 3*, *Race 4*, and *Race 5*. If the patient is multiracial, code all races using *Race 2* through *Race 5,*and code all remaining *Race* items 88.

b. All tumors for the same patient should have the same race code.

c. If *Race 1* is coded 99, then *Race 2* through *Race 5* must all be coded 99. If *Race 2, 3,* or *4* is coded 88 or 99, then all the subsequent *Race* items must be coded with the same value.

d. For cases diagnosed prior to January 1, 2000 (*Race Coding System-Current* is less than six), *Race 2* through *Race 5* must be blank unless the patient has more than one primary with at least one primary diagnosed after January 1, 2000. In this case, the race codes for all primaries must be the same as the one for the primary diagnosed after January 1, 2000. *Race Coding System –Current* must be six and data items *Race 2* through *Race 5* that do not have specific race recorded must be coded 88.

e. *Race 1* is the field used to compare with race data on cases diagnosed prior to January 1, 2000.

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

   If place of birth is China, Japan, or the Philippines, and race is not reported, code the race as 99 (Unknown). Place of birth alone cannot be used to determine race or ethnicity.

Codes with Examples:

01 A patient was born in Mexico of Mexican parentage. Code also *Spanish/Hispanic Origin.*

02 A black female patient. A specific 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.

05 A patient has a Japanese father and a Caucasian mother. (Caucasian will be coded in *Race 2*). If a person’s race is recorded as a combination of white and any other race, code to the other race in the *Race 1* field and then code Caucasian as “White” in the next race field.

05 A patient’s race is listed as Asian and the birthplace is Japan. Code to birthplace. When the race is recorded as “Oriental,” “Mongolian,” or “Asian,” and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation, code the race based on birthplace information.

07 A patient has a Hawaiian father, black mother, Japanese grandfather, and Korean grandmother. If a person’s race is recorded as a combination of Hawaiian and any other race(s), code the person’s primary race as Hawaiian and code the other races in *Race 2, Race 3, Race 4, and Race 5* as appropriate. In this case, black to *Race 2*; Japanese to *Race 3;* and Korean *to Race 4*.

08 A patient is of Korean and Asian ancestry. Do not code “Asian” in a subsequent race field if a specific Asian race(s) has already been coded.

25 A patient with a Polynesian mother, Tahitian father, and Samoan grandparents.

99 A patient’s race is unknown. *Race 2* through *Race 5* must also be 99.

Description for Spanish Origin

This item identifies persons of Spanish/Hispanic surname or ethnicity. Persons of Spanish/Hispanic origin may be of any race, but these categories are generally not used for native Americans, Filipinos, or others who may have Spanish surnames.

Codes for Spanish Origin

0 Non-Spanish; non-Hispanic; not Spanish surname
1 Mexican (includes Chicano)
2 Puerto Rican
3 Cuban
4 South or Central American (except Brazilian)
5 Other specified Spanish/Hispanic origin (includes European and third or fourth generation patients coded 1, 2, 3, or 4)
6 Spanish, NOS; Hispanic, NOS; Latino, NOS (There is evidence other than surname or birth surname that the person is Hispanic, but he/she cannot be assigned to any of the categories 1 to 5; Spanish/Hispanic surname but country of origin unknown.)

7 Spanish surname only (The only evidence of the person's Hispanic origin is surname or birth surname and there is no contrary evidence that the person is not Hispanic.)
9 Unknown whether Spanish or not

Code 7 was adopted for use effective with 1994 diagnoses. It does not include computer assignment of ethnicity.

Definitions and Rules for Spanish Origin

a. Use code 0 (Non-Spanish; non-Hispanic) for Portuguese and Brazilian persons.

b. Code European Spanish and Basque as other specified Spanish/Hispanic origin (Code 5).

c. Follow the rules for race in coding patients with mixed parentage.

d. If the patient has multiple tumors, all records should have the same code.

USUAL OCCUPATION

NAACCR Item #310

Item Length: 100
Data Type: Text
ACoS: N/A
State Registry: Required

Description
This is a required text field to record the patient's occupation, if available.

Rationale
Occupation is collected to meet the requirements of the Federal cancer registries grant. The item may be used to identify new work-related health hazards and to identify occupational groups in which cancer screening or prevention activities may be beneficial. It may also serve as an additional measure of socioeconomic status.

Instructions

a. Record the patient's usual occupation (that is, the kind of work performed during most of the patient's working life before diagnosis of this tumor). This may be different from the occupation at the time of diagnosis.

b. Do **not** record "retired." Do not add, "retired," to the usual occupation. (e.g., record "registered nurse" not "retired registered nurse.")

c. Do **not** record "disabled," "unemployed," or "institutionalized" if the patient was ever employed. Record the longest-held occupation.

d. If self-employed, specify the kind of work performed. (e.g., "self-employed auto mechanic")

e. If usual occupation is not available or is unknown, record the patient's current or most recent occupation or any known occupation.

f. If the patient was a homemaker (housewife/househusband) and also worked outside the home during most of his/her adult life, record usual occupation outside the home.

   If the patient was a homemaker (housewife/househusband) and did not work outside the home for most of his/her adult life, record "homemaker."

g. If the patient is less than 14 years of age at the time of diagnosis, record "child."

h. If the patient was a student at the time of diagnosis and had never held a job, record "student."

i. If the patient was not a student or homemaker and had never worked, record "never worked" as the usual occupation.

j If no information related to the patient's occupation is available, record "unknown."

k. Update this field if better information is obtained as to the usual occupation of the patient.

USUAL INDUSTRY

NAACCR Item #320

Item Length: 100
Data Type: Text
ACoS: N/A
State Registry: Required

Description
This is a required text field to record the company or industry, if available, for the occupation recorded in the preceding field.

Rationale
Both occupation and business/industry are required to accurately describe an individual's occupation. The item may be used to identify new work-related health hazards and to identify worksite-related groups in which cancer screening or prevention activities may be beneficial. It may also serve as an additional measure of socioeconomic status.

Instructions
a. Record the primary type of activity carried on by the business/industry where the patient was employed for the most number of years before diagnosis of this tumor. This may be different from the company or industry of the patient's occupation at the time of diagnosis.

b. Be sure to distinguish among "manufacturing," "wholesale," "retail," and "service" components of an industry that performs more than one of these components.

c. If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient to record the name of the company (with city or town) for which the patient performed his/her usual occupation.

d. If only current or most recent occupation (rather than usual occupation) is documented, record the patient's current or most recent business/industry.

e. There should be an entry for *Usual Industry* if any occupation is reported.
   - If *Usual Occupation* is "homemaker," record "own home" in *Usual Industry.*
   - If *Usual Occupation* is "child," record "child" in *Usual Industry.*
   - If *Usual Occupation* is "military," record "military" in *Usual Industry.*
   - If *Usual Occupation* is "student," record the type of school ("high school," "college") in *Usual Industry.*
   - If *Usual Occupation* is "never worked," record "none" in *Usual Industry.*
   - If no information is available regarding the industry in which the reported occupation was carried out, record "unknown" in *Usual Industry.*

f. Update this field if better information is obtained as to the usual industry of the patient.

TOBACCO USE SMOKING STATUS

Data Type: Numeric
ACoS: N/A
State Registry: Required

NAACCR Item #344

*Required for cases diagnosed 01/01/2022 and forward

Description
Record the patient's past or current use of tobacco (cigarette, cigar and/or pipe). Tobacco smoking history can be obtained from sections such as the nursing interview guide, flow chart, vital status or nursing assessment section, or other available source from the patient's hospital medical record or physician office record.

Rationale
Cigarette smoking is the leading preventable cause of death in the us and a major risk factor for cancer. Reducing tobacco use is a focus of CDC's National Center for Chronic Disease Prevention and Health Promotion. Reliable registry-based tobacco use data will help public health planners and clinicians target populations of cancer survivors for tobacco cessation. In addition, individual states have reported smoking data on patients are a useful covariate risk factor for cancer cluster investigations. Some state central cancer registries collect tobacco use data, but these variables are not standardized among registries. In addition to describing tobacco use patterns and trends in patients diagnosed with cancer, the collection of cigarette smoking history can enable researchers to better understand the association of cigarette smoking to cancer outcomes. Cigarette use data at diagnosis may help health professionals better understand how tobacco use impacts cancer prognosis, including how smoking is related to effectiveness of treatment and survival. In addition, this information is important to target and assess tobacco control efforts to cancer survivors and their families.

- Record cigarette, cigar, and/or pipe use only. Tobacco Use Smoking Status does not include marijuana, chewing tobacco, e-cigarettes, or vaping devices.
- Tobacco smoking history can be obtained from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats or Nursing Assessment section, or other available sources from the patient's hospital medical record or physician office record.
- Use code 1 if there is evidence in the medical record that the patient quit smoking within 30 days prior to diagnosis. The 30 days prior information is intended to differentiate patients who may have quit recently due to symptoms that led to a cancer diagnosis.
- Use code 2 if medical record indicates patient smoked tobacco in the past but does not smoke now. Patient must have quit 31 or more days prior to cancer diagnosis to be coded as 'Former smoker.'
- Use code 3 if it cannot be determined whether the patient currently smokes or formerly smoked. For example, the medical record only indicates "Yes" for smoking without further information.
- Use code 9 (Unknown if ever smoked) rather than code 0 (Never smoker), if o the medical record only indicates "No" for tobacco use; o smoking status is not stated or provided; or o the method (cigarette, pipe, cigar) used cannot be verified in the chart.
- This data item can be left blank for cases diagnosed prior to 1/1/2022

Code
0 Never smoker
1 Current smoker
2 Former smoker
3 Smoker, current status unknown
9 Unknown if ever smoked

OTHER PRIMARY TUMOR(S)

Data Type: Text
ACoS: N/A
State Registry: Required

Description
This is a required text field in the paper and WEBPLUS abstracts for recording any other primary, malignant tumors from the patient's history, or other primary tumors diagnosed simultaneously with or after the tumor being reported. Facilities using other types of registry software should follow their vendor's instructions for recording text about other primary tumors. *ISCR will no longer accept paper abstracts beginning 1/1/2026

Rationale
Text is needed to justify the codes selected for the data items and to record information that is not coded at all. The text is used for quality control and special studies.

Instructions
a. Record site, histology, date of diagnosis, and sequence number for all other primary, malignant tumors from the patient's history, or other primary tumors diagnosed simultaneously with or after the tumor being reported.

   Example: Right breast, infiltrating duct carcinoma, July 1980, 01

b. Follow the *SEER 2021 Solid Tumor Coding Rules* (a comprehensive revision of the *2007 Multiple Primary and Histology Coding Rules*).

c. If the person does not have, or has not had, another primary, malignant tumor, record "None."

DATE OF FIRST CONTACT
(INPATIENT OR OUTPATIENT ADMISSION DATE)

Item Length: 8
Data Type: Numeric
ACoS: Required
State Registry: Required

NAACCR Item #580

Description
This is a required 8-character field for the date the patient was first seen at or first admitted to your hospital for this tumor after your reference date. Use whichever date is earlier. Determine whether your software vendor uses the traditional format for date entry (MMDDCCYY) or the interoperable format (CCYYMMDD). The WEBPLUS program uses the traditional format.

Codes

Month		Day	Year
01	January	01	Use four-digit year (e.g., 2021)
02	February	02	blank = Year unknown
03	March	03	
04	April	...	
05	May	...	
06	June	25	
07	July	26	
08	August	...	
09	September	30	
10	October	31	
11	November	blank = Day unknown	
12	December		
blank	Month unknown		

Instructions

a. Record the first (earliest) date the patient was seen at your facility as either an inpatient or outpatient for diagnosis and/or first course treatment of a reportable tumor. The date may be the date of an outpatient visit for a biopsy, x-ray, or laboratory text, or the date a pathology specimen was collected at the facility.

b. For analytic cases (*Class of Case* 00-22), the *Date of First Contact* is the date the patient became analytic. For non-analytic cases, it is the date the patient first qualified for the *Class of Case* that causes the case to be abstracted.

c. If the patient was first seen as an outpatient, enter the date the patient was first seen in the outpatient department for this primary tumor. For cases diagnosed by scans or x-rays on an outpatient basis at your hospital and then admitted to your hospital, record the date of the scan or x-ray. If patient returned for subsequent outpatient visits, use only the initial date.

   Example: A patient has an MRI of the brain on December 7, 2014 for symptoms of severe headache and disorientation. The MRI findings are suspicious for astrocytoma. Surgery is performed on December 19, 2014, removing all gross tumor. *Date of First Contact* is December 7, 2014.

d. For cases diagnosed in the staff physician's office and then referred to your hospital for first course of therapy, record the date the patient was physically first seen at your hospital as an inpatient or outpatient.

   Example: A biopsy is performed in a staff physician's office on September 8, 2014. The biopsy specimen is read at the reporting facility's pathology department as malignant melanoma. The patient presents to the reporting facility for wide re-excision on September 14, 2014. *Date of First Contact* is September 14, 2014.

e. For cases diagnosed at another hospital, the date of first contact would be the date first seen at your hospital for treatment of this tumor, even if the patient was previously seen at your hospital as a consultation or for other reasons and no treatment was given for cancer.

f. If the primary was diagnosed during a long-term hospitalization (those in nursing homes, psychiatric facilities, or VA hospitals), use the date of diagnosis as the date of first contact.

   Example: A patient has been an inpatient for several months at a Veterans Administration Hospital for an unrelated illness. After having been hospitalized for several months a new primary is discovered during a routine exam. Enter the date the diagnosis was made, rather than the date the patient was first admitted to the VA Hospital.

g. If the cancer was not suspected while the patient was alive and hospitalized, but was an incidental finding on post mortem exam (autopsy), use the date of death as the date of first contact. There must be no suspicion of cancer prior to autopsy.

h. For cases diagnosed at your hospital prior to your reference (starting) date, record the first date seen for that malignancy after your reference date.

i. For pathology-only cases, record the date on which the specimen was collected.

j. If the date of first contact cannot be determined at all, leave the date of first contact field blank and record the reason in *Date of First Contact Flag*. See the *Date of First Contact Flag* section for examples illustrating the relationships among these items. **(No longer applicable for 1/1/2023+)**

Coding Tip: The year in the Date of First Contact item should match the first four digits of your hospital accession number for most patients' first primary (unless patient was admitted at the end of one year and not diagnosed until the next year).

DATE OF 1ST CONTACT FLAG

Item Length: 2
Data Type: Numeric
ACoS: Required
NAACCR Item #581
State Registry: Required

*Required if applicable for cases diagnosed 01/01/2015-12/31/2022

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of 1st Contact* (NAACCR Item #580). This data item was added to Volume II Version 12 (effective January 2010).

Rationale
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes
12 A valid date is applicable but not known. (The date of 1st contact is unknown.)
Blank A valid date is coded in the *Date of 1st Contact* item (NAACCR Item #580).

Instructions
a. Leave this item blank if *Date of 1st Contact* has a full or partial date recorded.
b. Use code 12 if the *1st Contact* cannot be determined at all.
c. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

Examples:

Description	Date (Leave unknown portions blank.)	Date of First Contact Flag
Full date known	*01/08/2021 or 2021/01/08	Blank
Month & year known	*01/_ _/2021 or 2021/01/_ _	Blank
Year only known	*_ _/_ _/2021 or 2021/_ _/_ _	Blank
Unknown date	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	12

***** For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The WEBPLUS program uses the traditional format. The computer will store either in the interoperable format.

HOSPITAL ACCESSION NUMBER

Item Length: 9
Data Type: Numeric
ACoS: Required
State Registry: Required

NAACCR Item #550

Description
This is a required 9-character field for the unique number assigned to each cancer patient seen at your hospital. The first 4 digits indicate a year (YYYY) and the next 5 digits indicate a sequential number (#####) in which the cancer was first entered into the registry, so that the accession number is recorded as YYYY#####. Each new calendar year starts over again on January 1 with accession number 00001.

Examples: 201200007; 201200014; 201200123; 201200537; 202100001.

Instructions

a. Assign accession numbers on a sequential basis, with the first four digits indicating the year the patient was first seen at your facility for the diagnosis and/or treatment of cancer. The last five digits indicate the numerical order in which the registry entered the case for that calendar year.

b. The first four digits of the accession number are based on the date the patient was first seen for the diagnosis and/or treatment of cancer at your hospital following your registry's reference date. The "reference date," which always begins on January 1 of a given year, is the date the hospital first started their registry. Therefore, the first four digits of the accession number is never less than the registry's reference date unless the reference date is changed (see ***Exception*** below).

   Example: If you began reporting cancer cases to the State Cancer Registry when the requirement began on January 1, 1987 and continue to report only for state requirements, your reference date would be January 1, 1987. All cases in your registry should have an accession number of 1987_ _ _ _ _ or higher.

   Exception: If a patient is first accessioned into the registry, then the registry later changes its reference date and the patient is subsequently accessioned into the registry with a new primary, use the original accession number associated with the patient and code the sequence appropriately.

   Example: A patient is diagnosed by the hospital with prostate cancer in 1991 and assigned accession number 199100067. The registry later sets a new reference date of January 1, 1997. The same patient is admitted and diagnosed with lymphoma in 2021. Use accession number 199100067 and sequence 02 for the lymphoma case.

c. Enter leading zeros for numbers less than five digits.

   Example: A patient is first admitted to your facility for treatment of cancer in 2021. The first four digits of the accession number are 2021. If the patient is the 25th patient to be accessioned (entered) in your registry in 2021, the last five digits of the accession number would be 00025. The full accession number for this patient would be 202100025.

d. Assign a unique accession number to each patient. A patient cannot have more than one accession number at your facility. Patients who contract a second or third primary cancer retain the same 9-digit accession number for primaries. (The sequence number will distinguish between the various primaries.)

   Before assigning an accession number to a patient, check your alphabetic index to see if the patient has ever been entered in your registry before. Do not assign a new accession number to a patient who already has another accession number.

Example: John Smith was first seen and diagnosed at your hospital in 1999 with a primary cancer of the prostate. He was assigned accession number 199900010-00 (1999 is the year first accessioned, 00010 is the accession number, and 00 is the sequence number). In 2021, he was diagnosed with a second primary cancer of the pancreas. The accession number for the pancreatic primary would be 199900010-02. The patient will always keep his originally assigned accession number. Only the sequence number changes. The sequence number will distinguish the two primaries.

e. Each new patient added to the registry should be given the next highest number in sequential order (202100001, 202100002, 202100003, etc.). The order patients are assigned an accession number within a particular year does not matter. Accession numbers do not need to be kept in date order of diagnosis, admission, discharge, or abstracting. For example, a case first seen in September 2021 (202100175) can have a lower accession number than a case first seen in July 2021 (202100176).

f. Do not skip over numbers to allow for earlier cases to be inserted later. Numeric gaps in accession numbers should occur only if a case is deleted from your database. Do not reuse the accession number for a different patient to avoid any chance of two cases having the same accession number.

g. The first four digits of the accession number are the year in which the patient was first seen at your hospital. If the patient's first primary was seen at another hospital and therefore was not recorded in your registry, enter the year the patient's earliest sequenced primary was diagnosed and/or treated at your facility.

Example 1: Mary Jones was diagnosed with her first primary malignancy at Hospital A in 2011. Hospital A gave her accession number 201100021-00, since she was the 21st patient to be accessioned at Hospital A in 2011. In 2021, Mary Jones went to Hospital B with a second primary. Hospital B assigned her accession number 202100152-02 since she was seen at hospital B for the first time in 2021 and was the 152nd patient entered in their registry. Hospital A should change their sequence number from 201100021-00 to 201100021-01.

Example 2: A new primary for a patient initially diagnosed and admitted in 2016 was not identified by the tumor registrar until 2021. The first four digits of the accession number would be 2016, based on the date of admission (date of first contact for this primary). It would not be 2021, the year the primary was identified by the registrar.

h. The first four digits of the accession number match the year recorded in *Date of First Contact* for the first accessioned primary (explained earlier in this chapter).

Example 1: A patient who was first seen as an outpatient in 2021 is the first patient to be entered into your registry in 2021. His accession number would be 202100001.

Exception: If the patient was first seen at your facility at the end of one year but was not diagnosed until the beginning of the next year, his accession number should be the year he was diagnosed.

Example 2: A patient first entered your hospital as an inpatient in December 2019, but was not diagnosed until January 2021. The first four digits of the accession number should be 2021, since the majority of the reports and service for this cancer would be provided in 2021.

HOSPITAL SEQUENCE NUMBER

NAACCR Item #560

Item Length: 2
Data Type: Numeric
ACoS: Required
State Registry: Required

Description
This is a required 2-character field for the number that indicates the chronological order of this primary tumor in relation to other reportable, independent, malignant and non-malignant neoplasms diagnosed in the patient's lifetime. The sequence number reflects all of a patient's reportable tumors, not just those seen at your hospital.

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.

Codes for Reportable Malignant or In Situ Primary Tumors:

Code	Definition
00	One malignant or in situ primary only in the patient's lifetime
01	First of two or more independent malignant or in situ primaries
02	Second of two or more independent malignant or in situ primaries
03	Third of three or more independent malignant or in situ primaries
...	
...	(actual sequence of this malignant or in situ primary)
...	
59	Fifty-ninth of fifty-nine independent malignant or in situ primaries
99	Unspecified malignant or in situ sequence number or unknown

Note: When this field is left blank in the WEBPLUS program, the system defaults to code "00."

Codes for Non-Malignant Tumors and Nonreportable Malignant or In Situ Tumors:

Code	Definition
60	Only one non-malignant primary
61	First of two or more independent non-malignant primaries
62	Second of two or more independent non-malignant primaries
...	
...	(Consecutive number of non-malignant primaries)
...	
87	Twenty-seventh of twenty-seven independent non-malignant primaries
88	Unspecified number of neoplasms in this category

Definitions
a. Hospital sequence number: The code indicating the sequencing of reportable neoplasms in the patient's lifetime, according to the information and rules of the hospital registry.

b. Central sequence number: The code indicating the sequencing of reportable neoplasms in the patient's lifetime, according to the information and rules of the central registry.

c. Reportable-by-agreement tumors: Diagnoses not required by CoC but defined as reportable by the facility's cancer committee or the state registry. Such diagnoses may be benign, borderline, or malignant. Diagnoses required by the NPCR and the Indiana State Cancer Registry, but not by CoC, include VIN III, VAIN III, and AIN.

Example: The State Registry requires the hospital to report vaginal intraepithelial neoplasia, grade III (VAIN III, 8077/2). The cancer committee adds VAIN III to their reportable-by-agreement list and decides to accession and abstract these cases to comply with State requirements.

d. The following table* illustrates the Indiana State Cancer Registry (ISCR) sequence number series by type of neoplasm.

Neoplasm	ISCR Sequence (Numeric Series)
Malignant (Behavior Code = 3) Includes AJCC T3, T4, or M1 Skin Squamous Cell and Basal Carcinomas diagnosed before 2003.	00-59
Pilocytic/Juvenile Astrocytoma diagnosed 2001 and later (Report as 9421/3 unless primary site is optic nerve.)	00-59
In Situ (Behavior Code = 2). Includes VIN III, VAIN III, AIN III. Includes Cervix CIS/CIN III diagnosed before 1996.	00-59
Cervix CIS/CIN III diagnosed 1996-2002	98
Cervix CIS/CIN III diagnosed 2003 and later	60-87
PIN III	60-87
Borderline/Benign Intracranial and Central Nervous System	60-87
Other Borderline/Benign	60-87
Skin Squamous Cell and Basal Carcinomas diagnosed 2003 and later	60-87

*Adapted from the "*SEER Program Coding and Staging Manual 2021*."

Instructions

a. Use codes 00-59 and 99 for reportable invasive or in situ neoplasms.

b. Use codes 60-88 for non-malignant neoplasms and nonreportable invasive or in situ neoplasms.

c. Use Code 00 only if the patient has a single invasive or in situ primary. If the patient develops a subsequent invasive or in situ primary tumor, change the code for the first tumor from 00 to 01, and number subsequent tumors sequentially.

Example 1: Use code 00 for a patient with no history of previous cancer is diagnosed within situ breast carcinoma January 13, 2021.

Example 2: Change the sequence to 01 for the January 13, 2021 breast carcinoma when the patient is diagnosed with a subsequent skin melanoma on July 30, 2021.

Example 3: Assign sequence 02 to the skin melanoma diagnosed on July 30, 2021 following a breast carcinoma diagnosed on January 13, 2021.

Use sequence 00 if there is no information available to indicate the patient has been diagnosed with an earlier primary malignancy. Assume the tumor being reported is the first. A history of surgery such as hysterectomy or colectomy should not be interpreted as evidence of an earlier malignancy without confirmation, since surgery is also performed to treat benign conditions.

d. Use sequence 99 only when there is information that suggests the possibility of an earlier malignancy, but the medical record does not document a definite diagnosis.

Example: A patient is diagnosed in the reporting hospital with cancer of the colon. The medical record contains the statement, "The patient recently had a salivary gland tumor removed. The patient does not know if the lesion was malignant." The registry assigns sequence number 99 to the colon primary. The patient returns to the reporting facility a year later for prostate cancer treatment. The medical record states, "The patient has a

history of a malignant salivary gland tumor." Change the sequence number of the colon cancer from 99 to 02. Assign the sequence number 03 to the prostate cancer.

e. If a patient has had a reportable tumor that the facility did not accession, it is accounted for in sequencing subsequent tumors.

Example 1: Your hospital diagnoses a patient with colon cancer. The patient has a history of kidney cancer diagnosed and treated elsewhere. Assign sequence number 02 to the colon cancer.

Example 2: A patient is diagnosed with breast cancer in 1985. Hospital A's reference date is 1987. In 2021, this patient has a primary of the lung. Assign sequence number 02 to the lung cancer.

f. Sequence numbers should be reassigned if the facility learns later of an unaccessioned tumor that would affect the sequence.

g. If two or more primaries 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.

Example 1: A patient enters your facility with simultaneous invasive carcinoma of the cervix and invasive adenocarcinoma of the colon. Assign sequence number 01 to the colon primary and sequence number 02 to the cervix primary.

Example 2: A patient has simultaneous adenocarcinoma in situ in a colon polyp and squamous cell carcinoma in situ in a vocal cord polyp. Assign sequence numbers as you choose. Both primaries have similar prognoses.

h. Use code 60 only if the patient has single non-malignant primary. If the patient develops a subsequent non-malignant primary tumor, change the code for the first tumor from 60 to 61, and assign codes to subsequent non-malignant tumors sequentially.

i. The sequence codes for malignant/in situ and non-malignant cases are assigned independently. Assign sequence 60 to the first non-malignant tumor in a patient with a prior malignant or in situ primary with sequence number 00.

CLASS OF CASE

Item Length: 2
Data Type: Numeric
ACoS: Required
State Registry: Required

NAACCR Item #610

Description
For a hospital registry, 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 treatment. Treatment and outcome reports may be limited to analytic cases. Nonanalytic cases (codes 30-49 and 99) may be abstracted by the facility to meet central registry requirements or because of 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.

Class of Case can be used in conjunction with Type of Reporting Source [500]. Type of Reporting Source is designed to document the source of documents used to abstract the cancer being reported.

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.

Codes

Analytic Classes of Case (Required by CoC to be abstracted by approved programs)
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 an office of a physician with admitting privileges AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS
11 Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at the reporting facility
12 Initial diagnosis in an office of a physician with admitting privileges AND all first course treatment or a decision not to treat was done at the reporting facility
13 Initial diagnosis AND part of first course treatment was done at the reporting facility
14 Initial diagnosis AND all first course treatment or a decision not to treat was done at the reporting facility
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 treatment was done at the reporting facility
22 Initial diagnosis elsewhere AND all treatment was done at the reporting facility

Classes of Case not required by CoC to be abstracted; required by Cancer Committee, state or regional registry, or other entity

Patient appears in person at reporting facility
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) having initial diagnosis AND part or all of first course treatment by reporting facility
35 Case diagnosed before program's Reference Date, having initial diagnosis AND part or all of first course treatment by reporting facility
36 Type of case not required by CoC to be accessioned (for example, a benign colon tumor) having initial diagnosis elsewhere AND all or part of first course treatment by reporting facility
37 Case diagnosed before program's Reference Date, having 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 treatment given in two or more different offices of physicians with admitting privileges
42 Non-staff physician or non-CoC approved 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 Case not required by CoC to be abstracted of unknown relationship to facility (not for use by CoC approved cancer programs for analytic cases.)

Definitions

a. Initial diagnosis: This refers to the first time a physician indicates that the patient has cancer. The initial diagnosis may be clinical or microscopic and it may be based on ambiguous terminology.

b. Treatment: Treatment includes any first course activity coded as *Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery, Surgical Procedure/Other Site, Radiation Treatment, Chemotherapy, Hormone Therapy, Immunotherapy, Hematologic Transplant and Endocrine Procedures*, or *Other Treatment*.

   Palliative care (undertaken to reduce the patient's symptoms) involving surgery, systemic treatment, or radiation is also coded as treatment and qualifies the patient as analytic if given as part of planned first course treatment.

   Decisions not to treat, whether initiated by the physician (contraindicating conditions) or by the patient (refusal), or decisions for active surveillance ("watchful waiting") are also considered treatment for assigning Class of Case.

c. Physicians with admitting privileges: Physicians who are not employed by the reporting facility but are under contract with it or have routine admitting privileges there.

Instructions

a. Assign the Class of Case code that most precisely describes the patient's relationship to the facility.

b. It is possible that information for coding Class of Case will change during the patient's first course of care. Change the Class of Case code accordingly if that occurs.

   If a patient has been accessioned into your registry as an analytic case (codes 00-22), do not re-accession or change the class of case code if the patient returns for a recurrence, subsequent treatment, or progression of disease involving the same primary.

c. Assign code 00 only when it is known that the patient went elsewhere for treatment. If it is not known that the patient actually went somewhere else, assign Class of Case code 10.

d. Report all analytic cases (codes 00-22), to the State Cancer Registry.

e. Report specified nonanalytic cases (codes 30, 32, 34-38, 40-41) that meet criteria described in Chapter 3 of this manual.

NPI-INSTITUTION REFERRED FROM

Item Length: 10
Data Type: Numeric
Right Justify, Zero Fill
ACoS: Required
State Registry: Required

NAACCR Item #2415

Description
This is a required 10-character field for recording an identification number for the facility from which the patient was referred. This field is used to identify referral patterns and is important for tracking patients within the statewide database.

Codes
Record the 10-digit NPI for the referring facility. NPI numbers for Indiana facilities are provided in Appendix D of this manual.

Instructions
a. Identify the referring facility only if the cancer being reported was definitively diagnosed and/or treated at the referring facility.

b. Leave the item blank for the following:
   - The NPI for the referring facility is unknown or not available; or
   - The patient was not referred to the reporting facility from another facility.

NPI-INSTITUTION REFERRED TO

Item Length: 10
Data Type: Numeric
Right Justify, Zero Fill
ACoS: Required
State Registry: Required

NAACCR Item #2425

Description
This is a required 10-character field for recording an identification number for the facility to which the patient is referred for definitive treatment after discharge from your facility. This field is used to identify referral patterns and is important for tracking patients within the statewide database.

Codes
Record the 10-digit NPI for the referring facility. NPI numbers for Indiana facilities are provided in Appendix D of this manual.

Instructions
a. If the patient was referred to more than one hospital for definitive treatment, record the code for the first hospital to which the patient was referred.

b. Leave the item blank for the following:
   - The NPI for the facility referred to is unknown or not available; or
   - The patient was not referred to another facility.

IF DIAGNOSED ELSEWHERE, RECORD WHERE

Data Type: Text
ACoS: N/A
State Registry: Required

Description
This is a required text field for recording where the patient was diagnosed, if not at your facility. The item is required if applicable and available.

Rationale
Text is needed to justify the codes selected for the data items and to record information that is not coded at all. The text is used for quality control and special studies.

Instructions
a. Record the name of the facility or physician's office where the patient was diagnosed.

Examples: Name of another hospital, physician (by name) office, name of freestanding clinic, etc.

b. If the patient was diagnosed in your facility, leave the field blank.

c. Record "unknown" if the patient was diagnosed elsewhere, but it is unknown where.

CASEFINDING SOURCE

Item Length: 2
Data Type: Numeric
ACoS: N/A
State Registry: *Required

NAACCR Item #501

*Required if available for cases diagnosed 01/01/2012 and later.

Description
This is a required 2-character field for coding the source that first identified the tumor. For cases identified by a source other than reporting facilities (such as through death clearance or as a result of an audit), the codes reflect the type of source through which the tumor was first identified.

Rationale
This data item will help reporting facilities as well as regional and central registries in prioritizing their casefinding activities. It will identify reportable tumors that were first found through death clearance or sources other than traditional reporting facilities. It provides more detail than "Type of Reporting Source." This data item cannot be used by itself as a data quality indicator. The timing of the casefinding processes (e.g., death linkage) varies from registry to registry, and the coded value of this variable is a function of that timing.

Codes
Case first identified at a reporting facility

- 10 Reporting hospital, NOS
- 20 Pathology department review (surgical pathology reports, autopsies, or cytology reports)
- 21 Daily discharge review (daily screening of discharged patients' records in the medical record/health information department)
- 22 Disease index review (review of the medical record/health information department's disease index)
- 23 Radiation therapy department/center
- 24 Laboratory reports (other than pathology reports defined for code 20)
- 25 Outpatient chemotherapy
- 26 Diagnostic imaging/radiology, including nuclear medicine (other than radiation therapy, code 23)
- 27 Tumor board
- 28 Hospital rehabilitation service or clinic
- 29 Other hospital source (including clinic, NOS or outpatient department, NOS)

Case first identified by source other than a reporting facility covered in the above codes (10-29)

- 30 Physician-initiated case
- 40 Consultation-only or pathology-only report (not abstracted by reporting hospital)
- 50 Independent (non-hospital) pathology-laboratory report
- 60 Nursing home-initiated case
- 70 Coroner's office records review
- 75 Managed Care Organization (MCO) or insurance records
- 80 Death certificate (case identified through death clearance)
- 85 Out-of-state case sharing
- 90 Other non-reporting hospital source
- 95 Quality control review (case initially identified through quality control activities such as casefinding audit of a regional or central registry)
- 99 Unknown

Instructions
1. For State reporting, this item may be left blank for cases diagnosed before 2012.

2. Determine where the case was first identified and assign the appropriate code.

   If the case was first identified at a reporting facility (codes 10-29), assign the code for the earliest source of identifying information (based on patient or specimen contact at the facility).

At the regional or central level, if a hospital and a non-hospital source identified the case independently of each other, the code for the non-hospital source should be assigned. Codes 30-95 have priority over codes 10-29.

3. If a death certificate, independent pathology laboratory report, consultation-only report from a hospital, or other report was used to identify a case that was then abstracted from a different source, assign the code for the source that first identified the case, not the source from which it was subsequently abstracted.

4. If a regional or central registry identifies a case and asks a reporting facility to abstract it, assign the code that corresponds to the initial source, not the code that corresponds to the eventual reporting facility.

DATE OF INITIAL DIAGNOSIS

Item Length: 8
Data Type: Numeric
ACoS: Required
State Registry: Required

NAACCR Item #390

Description
This is a required 8-character field for the date this primary cancer was diagnosed by a recognized medical practitioner. Determine whether your software vendor uses the traditional format for date entry (MMDDCCYY) or the interoperable format (CCYYMMDD). The WEBPLUS program uses the traditional format.

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

Codes

	Month	Day	Year
01	January	01	Use four-digit year (e.g., 2021)
02	February	02	blank = Year unknown
03	March	03	
04	April	...	
05	May	...	
06	June	25	
07	July	26	
08	August	...	
09	September	30	
10	October	31	
11	November	blank = Day unknown	
12	December		
blank	Month unknown		

Definition
This date refers to the date this cancer was diagnosed by any recognized medical practitioner. The first diagnosis is often clinical and may never be histologically confirmed. Refer to the list of terms that represent a clinical diagnosis in Chapter 4. Do not change the date of diagnosis when a later biopsy or cytology provides confirmation of a clinical diagnosis. Even if confirmed later, the diagnosis date refers to the date of the first clinical diagnosis and not to the date of confirmation. The date of the first clinical diagnosis provides a more accurate picture of the true survival time from date of diagnosis to death when determining survival statistics.

Example 1: A March 12, 2021 mammogram reveals a mass in the upper-outer quadrant of a patient's right breast compatible with carcinoma. On March 20, 2021, the patient has an excisional breast biopsy that confirms infiltrating ductal carcinoma. Date of diagnosis is March 12, 2021.

Example 2: A physician notes a prostate nodule that is suspicious for cancer during a May 11, 2021 physical examination. On June 15, 2021, an ultrasound guided needle biopsy of the prostate provides histologic confirmation of adenocarcinoma. Date of diagnosis is May 11, 2021.

Instructions
a. If the physician says that in retrospect, the patient had cancer at an earlier date, use that earlier date as the date of diagnosis. When a tumor has been diagnosed as benign and a later medical or pathologic review of previous slides or x-ray films changes this to a diagnosis of a malignancy, the original date of diagnosis is considered to be the date of the initial slide or film review. In other words, the date of diagnosis is backdated.

   Example: A patient has a total abdominal hysterectomy for endometriosis in January 2014. The patient is admitted with abdominal pain and distention in November 2015. A laparoscopy with omental biopsy shows metastatic cystadenocarcinoma. Pathologists review the 2014

hysterectomy specimen. They identify an area of cystadenocarcinoma in the left ovary. Date of diagnosis is January 2014 (01/_ _/2014).

b. The date of the histology, cytology, or tissue exam should be used only if that is the first date the cancer was diagnosed or if the date of initial, clinical diagnosis is unknown and it is the earliest alternative confirmation.

c. If the date of initial clinical diagnosis is unknown but the diagnosis has been confirmed microscopically or through radiologic or other exam, use the date of the histology, cytology, tissue, or radiologic exam, whichever is earlier. In some cases, this may be a date prior to admission.

d. Use the date of first cancer-directed therapy as the date of diagnosis if the cancer-directed therapy was started prior to the definitive diagnosis of cancer.

e. The date of death is the date of diagnosis for class of case code 38 (first diagnosed at autopsy) or 49 (death certificate only).

f. Use the actual date of diagnosis for an *in utero* diagnosis, for cases diagnosed January 1, 2009 or later.

g. For patients diagnosed prior to admission to your facility, record the date of diagnosis from the referring hospital, practitioner, or clinic, if known. If the date is unknown, record the best estimate as described in paragraph h. below.

h. If you do not know the exact date of diagnosis, estimate the date based on available information. Recording an approximate date is preferable to recording an unknown date.

   Every attempt should be made to enter the month and day, even if an estimate is necessary. If there is no basis for approximation, leave the month and day spaces blank.

   If the year diagnosis cannot be identified, it must be approximated. In that instance, the month and day are unknown. Leave the month and day spaces blank.

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

Descriptive Term Used	Date Code
Spring	April
The middle of the year	July
Fall	October
Winter	Try to determine if this means the beginning of the year (January) or the end of the year (December). Code as indicated.

j. If the date of diagnosis cannot be determined at all, leave the date of diagnosis blank and record the reason in *Date of Diagnosis Flag*. See the *Date of Diagnosis Flag* section for examples illustrating the relationships among these items. **(No longer applicable for 1/1/2023+)**

DATE OF DIAGNOSIS FLAG

Item Length: 2
Data Type: Numeric
ACoS: N/A
NAACCR Item #391
State Registry: Required

*Required if applicable for cases diagnosed 01/01/2015-12/31/2022

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of Diagnosis* (NAACCR Item #390).

Rationale
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes
12 A valid date is applicable but not known. (The date of diagnosis is unknown.)
Blank A valid date is coded in the *Date of Diagnosis* item (NAACCR Item #390).

Instructions
a. Leave this item blank if *Date of Diagnosis* has a full or partial date recorded.
b. Use code 12 if the *Date of Diagnosis* cannot be determined at all.
c. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

Examples:

Description	Date (Leave unknown portions blank.)	Date of Diagnosis Flag
Full date known	*01/08/2021 or 2021/01/08	Blank
Month & year known	*01/_ _/2021 or 2021/01/_ _	Blank
Year only known	*_ _/_ _/2021 or 2021/_ _/_ _	Blank
Unknown date	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	12

* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The WEBPLUS program uses the traditional format. The computer will store either in the interoperable format.

PRIMARY SITE

NAACCR Item #400

Item Length: 4
Data Type: Numeric
ACoS: Required
State Registry: Required

Description
This is a required 4-character field for recording the topography (anatomic site) code that best describes the primary site of malignancy. Metastatic lesions are NEVER coded in this field. Review the entire medical record before assigning this code.

General Instructions

a. Enter the topography (anatomic site) code from the Topography section of the *International Classification of Diseases for Oncology,* Third Edition, 2000 (*ICD-O-3*)* that best describes the primary site of the tumor. The topography code should first be located in the Alphabetic Index (pages 105-218). Then the specific topography should be located in the Topography – Numerical List section (pages 45-65). The Alphabetic Index includes both topography and morphology terms.

   ***Note:** *ICD-O-3* is effective for cases diagnosed January 1, 2001 forward. Continue to use *ICD-O-2* for cases diagnosed prior to 2001.

b. For reportable solid tumors diagnosed January 1, 2018 or later, follow the instructions in *ICD-O-3*, pages 20-40 and the SEER *2018 Solid Tumor Coding Rules* (a comprehensive revision of the *2007 Multiple Primary and Histology Coding Rules*).

   Exception: For Cutaneous Melanoma and Other Sites (excluding rectosigmoid, rectum, and peripheral nerves), continue to use the *2007 Multiple Primary and Histology Coding Rules and General Instructions.*

c. For lymphoma, leukemia and other hematopoietic neoplasms diagnosed 2010 and later use the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database. Do not use *ICD-O-3* for the lymphoma, leukemia and other hematopoietic neoplasms diagnosed 2010 and later.

d. Record the primary site as specifically as possible. For example, if the final diagnosis is “cancer of the colon,” review other reports in the medical record (e.g., operative note, pathology report, radiology reports, and physician progress notes) to ascertain whether a more specific site within the colon can be identified.

e. It is important that the primary site be coded, rather than a metastatic site. The primary site is the location where the cancer first developed, or the site of origin of a tumor. A metastatic site is the location to which the cancer has spread, or metastasized, from the primary site. Ask your physician advisor to identify the primary site or the most definitive site code if the medical record does not contain that information.

f. Use the subcategory 8 (C_ _.8) for single tumors that overlap the boundaries of two or more sub-sites and the point of origin is unknown.

   Example 1: Code overlapping lesion (C10.8) 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.

   Example 2: Code overlapping lesion of the bladder (C67.8) when one lesion involves the dome (C67.1) and the lateral wall (C67.2) and the point of origin is not stated.

g. Use the subcategory 9 (C_ _.9) for multiple tumors that originate in multiple sub-sites of one organ.

   Example 1: Code bladder, NOS (C67.9) when multiple lesions arise in both the trigone (C67.0) and lateral wall (C67.2).

Example 2: Code lung, NOS (C34.9) when there are lesions in both the right middle lobe (C34.2) and the right lower lobe (C34.3) of lung.

Example 3: Code breast, NOS (C50.9) when there are lesions in both the left lower-inner quadrant (C50.3) and the left lower-outer quadrant (C50.5) of a breast.

Note: When multiple tumors are all located in the same quadrant of the breast, code the specific quadrant.

h. If the specific site within an organ cannot be determined, code the primary site to the "NOS" (Not Otherwise Specified) category of the organ, organ system, or region. Refer to codes C76.0 to C76.8 (Other and Ill-Defined Sites) before coding C80.9 (Unknown primary site). For occult cervical lymph nodes and cutaneous carcinoma of the head and neck, follow the instructions under "Diagnosis-Specific Instructions," paragraphs c. and d. below.

If an unknown site is later specifically identified, the primary site code should be changed to the correct one.

Example: Your hospital clinically diagnoses a patient with carcinomatosis. The registry enters the case as an unknown primary (C80.9), carcinoma, NOS (8010/3), stage of disease unknown. Nine months later a paracentesis shows serous cystadenocarcinoma. The physician states that the patient has an ovarian primary. Change the primary site to ovary (C56.9), histology to serous cystadenocarcinoma (8441/3), and diagnostic confirmation to positive exfoliative cytology, no positive histology (2).

Diagnosis-Specific Instructions

a. Kaposi sarcoma
- Code Kaposi sarcoma to the site in which it arises.
- Code to skin (C44.9) if Kaposi sarcoma arises simultaneously in the skin and another site, and the primary site is not identified.

b. Melanoma
- Code to Skin NOS (C44.9) if the diagnosis is metastatic melanoma and the primary site is not identified.

c. Occult Cervical Lymph Nodes
For a head and neck primary lymph node involvement with no head and neck tumor found or specified by a physician, code the primary site according to the instructions described below.
- Use code C76.0 if the neck node has not been tested or is negative for both HPV and EBV.
- Use code C10.9 if the neck node is p16 positive, indicating human papillomavirus (HPV) and EBV negative or unknown.
- Use code C11.9 if the neck node is EBER positive, or both EBER and p16 positive, indicating Epstein Barr Virus (EBV).

Code Schema Discriminator 1: Occult Head and Neck Lymph Nodes according to the SSDI Manual guidelines. The SSDI manual has further information for assigning the primary site code.

d. Cutaneous Carcinoma of the Head and Neck
For (nonmelanoma) skin cancers of overlapping sites in the head and neck only, assign the primary site code for the site where the bulk of the tumor is or where the epicenter is. Do not use code C44.8 (Overlapping lesion of skin).

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

Histology	*ICD-O-3* Codes	Code to This Site
Melanoma	8720-8790	C44._ Skin
Sarcoma except periosteal fibrosarcoma and dermatofibrosarcoma	8800-8811, 8813-8830, 8840-8921, 9040-9044	C49._ Connective, Subcutaneous, and Other Soft Tissues
Mesenchymoma	8990-8991	C49._ Connective, Subcutaneous, and Other Soft Tissues
Blood vessel tumors, lymphatic vessel tumors	9120-9170	C49._ Connective, Subcutaneous, and Other Soft Tissues
Granular cell tumor and alveolar soft part sarcoma	9580-9582	C49._ Connective, Subcutaneous, and Other Soft Tissues
Mesenchymal chondrosarcoma and giant cell tumors	9240-9252	C40._, C41._for Bone and Cartilage C49._ Connective, Subcutaneous, and Other Soft Tissues
Mixed tumor, salivary gland type	8940-8941	C07._ for Parotid Gland C08._ for Other and Unspecified Major Salivary Glands

f. In the absence of any additional information about the primary site, assign the codes listed for the primary sites/histologies in the table provided below. Source: *SEER Program Coding and Staging Manual 2018*.

Primary Site/Histology	Code
Anal margin	C445
Anal verge	C211
Angle of the stomach	C162
Angular incisura of stomach	C163
Book-leaf lesion (mouth)	C068
Colored/lipstick portion of upper lip	C000
Cutaneous leiomyosarcoma	C44_
Distal conus	C720
Edge of tongue	C021
Frontoparietal (brain)	C718
Gastric angular notch (incisura)	C163
Glossotonsillar sulcus	C109
Incisura, incisura angularis	C163
Infrahilar area of lung	C349
Leptomeninges	C709
Masticatory space	C069
Melanoma, NOS	C449
Nail bed, thumb	C446
Pancreatobiliary	C269
Parapharyngeal space	C490
Perihilar bile duct	C240
Testis, descended post orchiopexy	C621

LATERALITY

NAACCR Item #410

Item Length: 1
Data Type: Numeric
ACoS: Required
State Registry: Required

Description
This is a required 1-character field for recording a code that identifies the side of a paired organ or the side of the body on which the tumor originated. Laterality refers to the primary site only and should be coded independently for each primary. Metastatic involvement is not coded.

Codes
0 Not a paired organ or site; not applicable; unknown primary site
1 Right side is origin of primary
2 Left side is origin of primary
3 Only one side is involved; right or left origin unspecified
4 Bilateral involvement, side of origin unknown; stated to be a single primary.
Includes: Both ovaries involved simultaneously with a single histology
Bilateral retinoblastomas
Bilateral Wilms tumors
5 Paired site: midline tumor
9 Paired site, but no information on laterality

Instructions
a. If only one histologic type is reported and if both sides of a paired site are involved within two months of diagnosis, determine whether the patient had one or two independent primaries. Refer to the SEER *2018 Solid Tumor Coding Rules*.

(1) If there are two primaries, prepare two abstracts, recording the appropriate laterality and extent of disease for each.

(2) If there is only one primary (originated on one side and metastasized to the other), prepare a single abstract and code laterality according to the side where the primary originated. If it is not possible to determine the side where the primary originated, record laterality code 4 (bilateral involvement, lateral origin unknown).

b. Record laterality for unknown primary site (C80.9) as 0 (not a paired organ or site).

c. The following list identifies the paired organs or paired sites. For all sites that are not on the list, record laterality code 0 (not a paired organ; not applicable). The *STORE* laterality rules permit coding non-paired sites as right or left but the State Registry does not support this.

Use laterality code 1 – 9 only for the following sites, except as noted. The listing includes only major categories. Code laterality for all subheadings included in *ICD-O-3* under these headings, unless specifically excluded. Exclusions should be coded as “0.”

ICD-O-3 Primary Site Code	Paired Organ or Site
C07.9	Parotid gland
C08.0	Submandibular gland (submaxillary gland)
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum – use code 0)
C30.1	Middle ear (Eustachian tube)
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina – use code 0)
C34.1-C34.9	Lung **Note:** C34.2 Middle lobe is on right side only – laterality code 1
C38.4	Pleura, NOS
C40.0	Long bones of upper limb, scapula, and associated joints (bones of arm)
C40.1	Short bones of upper limb and associated joints (bones of hand)
C40.2	Long bones of lower limb and associated joints (bones of leg)
C40.3	Short bones of lower limb and associated joints (bones of foot)
C41.3	Rib and clavicle (excluding sternum – use code 0)
C41.4	Pelvic bones and associated joints (excluding sacrum, coccyx, and symphysis pubis – use code 0)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face (if site is non-paired or on midline, such as chin, record laterality code 9)
C44.4	Skin of scalp and neck (2021+ diagnosis years only)
C44.5	Skin of trunk (if site is non-paired or on midline, record laterality code 9)
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 (vas deferens)
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0-C69.9	Eye and adnexa (including lacrimal gland)
C74.0-C74.9	Adrenal gland (suprarenal gland)
C75.4	Carotid body

For malignant and benign/borderline tumors diagnosed January 1, 2004 or later, the following central nervous system sites require a valid laterality code:

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

C72.4 Acoustic nerve
C72.5 Cranial nerve, NOS

d. The primary site codes listed below include both paired and a non-paired sub-sites.

Code	**Paired Sub-Sites** (Use laterality codes 1 – 9)	**Non-Paired Sub-Sites** (Use laterality code 0 or 9 as indicated below.)
C30.0	nasal cavity	nasal cartilage, nasal septum (0)
C34.0	main bronchus	carina (0)
C41.3	rib, clavicle	sternum (0)
C41.4	pelvic bones	sacrum, coccyx, symphysis pubis (0)
C44.3	skin of cheek, temple, eyebrow	skin of chin, face, nose, forehead (9)
C44.5	skin of abdomen, axilla, back, breast, buttock, chest	skin of anus (9)

Example: When coding for the main bronchus (C34.0), if bronchus (a paired organ) is the primary site, enter code 1, 2, 3, 4, or 9. Use code 0 if the carina (a non-paired organ) is the primary site.

e. Text Documentation
Include laterality for applicable sites when recording the description of the primary site in the text area of the abstract. Staff at the State Cancer Registry will then know whether to override (bypass) an edit that identifies an inconsistency between site and laterality codes.

DIAGNOSTIC CONFIRMATION

Item Length: 1
Data Type: Numeric
ACoS: Required
State Registry: Required

NAACCR Item #490

Description
This is a required 1-character field for recording the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history. It indicates whether at any time during the patient's disease course there was microscopic confirmation of the morphology of this cancer.

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 procedures include sources outside of pathology reports. Complete casefinding must include both clinically and pathologically confirmed cases.

Codes and Definitions for Solid Tumors (all tumors except M9590-9993)

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 that are clinically diagnostic for cancer. Examples include alpha-fetoprotein for liver cancer. Elevated PSA is not diagnostic of cancer. If the physician uses the PSA as a basis for diagnosing prostate cancer with no other work-up, 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. Diagnosed by radiology, including ultrasound, computed (axial) tomography (CT or CAT scans), and magnetic resonance imaging (MRI).
8	Clinical diagnosis only (other than 5, 6, or 7)	The malignancy was reported by the physician in the medical record. Refer to ambiguous terminology in Chapter 4.
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 Solid Tumors (all tumors except M9590-9993)

a. The codes are in priority order, with code 1 having the highest priority. Always code the diagnostic method with the lower numeric value when the diagnosis of cancer is confirmed with multiple methods. Change this data item to the lower (higher priority) code if a more definitive method confirms the diagnosis at any time during the course of the disease.

   Example: A chest x-ray dated 02/01/2021 diagnoses a probable lung cancer. The patient refuses a diagnostic work-up. The registry codes the diagnostic confirmation to radiography (code 7). The patient allows a lymph node biopsy on 04/12/2021. The biopsy confirms small cell carcinoma. Change the diagnostic confirmation code to positive histology (code 1).

b. Assign code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, autopsy, dilatation and curettage (D & C), bone marrow biopsy or bone marrow aspiration (bone marrow FNA).

c. Assign code 2 when the microscopic diagnosis is based on cytologic examination of cells. The cells may be recovered from exudate, scrapings, secretions, or washings from tissue: sputum smears, bronchial brushings, bronchial washings, tracheal washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical and vaginal smears, or from paraffin-block specimens from concentrated spinal, pleural, or peritoneal fluid.

d. Assign code 4 when the case is reported as microscopically confirmed, but no information is provided about the method (histology, cytology). This may include cases where the medical record or physician states the histology type, but there is no path report in the record.

e. Assign code 8 when the case was diagnosed by any clinical method not mentioned in preceding codes. 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.

f. If diagnosis was confirmed at another hospital, enter the code for how the other hospital confirmed the diagnosis, if known, unless further confirmation with a lower code occurred at your facility. (e.g., If the other hospital performed a mammogram and your hospital performed a biopsy, code the biopsy.) If unknown, enter code 9.

g. Some cytology specimens contain tissue. Some pathology/tissue specimens contain only cells or fluid aspiration. Read the report carefully to determine if the pathologist examined cells or tissue and code accordingly.

Codes and Definitions for Hematopoietic and Lymphoid Neoplasms (M9590-9993)

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** ▪ 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)(p13.1q22) (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 that 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. Refer to ambiguous terminology in Chapter 4.
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 and Lymphoid Tumors (M9590-9993)

a. There is no priority hierarchy for 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.

b. Assign code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, autopsy or bone marrow specimens from aspiration or biopsy.

c. For leukemia only, assign code 1 when the diagnosis is based only 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.

d. Assign 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 or vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. These methods are rarely used for hematopoietic or lymphoid tumors.

e. Assign code 3 when there are 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

f. Assign code 5 when the diagnosis of cancer is based on laboratory tests or marker studies that are clinically diagnostic for that specific cancer, but no positive histologic confirmation.

g. Assign code 6 when the diagnosis is based only on the surgeon's report from a surgical exploration or endoscopy or from gross autopsy findings without tissue or cytological findings.

h. Assign code 8 when the case was diagnosed by any clinical method not mentioned in preceding codes. 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.

HISTOLOGY

Item Length: 4
Data Type: Numeric
ACoS: Required
State Registry: Required

NAACCR Item #522

Description
This is a required 4-character field for recording histologic (cell) type.

Instructions
For cases diagnosed January 1, 2021 or later, first check the 2021 *ICD-O-3.2* Update Tables at the following link to determine if the histology is listed. https://www.naaccr.org/implementation-guidelines/#ICDO3. **The tables can be saved to your desktop or printed.**
The 2021 tables include instructions for cases diagnosed prior to 2021. If the histology is not included in the update, then refer to *ICD-O-3*. Use the *ICD-O-3* references jointly with the rules listed below, as applicable.

- **For all solid reportable tumors diagnosed January 1, 2018 or later, use the SEER *2018 Solid Tumor Coding Rules* (a comprehensive revision of the *2007 Multiple Primary and Histology Coding Rules*).** For 2021 the rules include an updated section for cutaneous melanomas. *Exception:* For Other Sites (excluding rectosigmoid, rectum, and peripheral nerves), continue to use the *2007 Multiple Primary and Histology Coding Rules and General Instructions.*
- **For lymphoma, leukemia, and other hematopoietic tumors diagnosed 2010 and later use the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database.** Do not use *ICD-O-3* for the lymphoma, leukemia and other hematopoietic neoplasms diagnosed 2010 and later. Most recent version published 08/2021.

Note: For cases diagnosed before to 2021, refer to the applicable prior version of the Indiana State Cancer Registry Policy and Procedure Manual.

a. Enter the five-digit code from the Morphology Section of the *International Classification of Diseases for Oncology,* Third Edition, 2000 (*ICD-O-3*)* that best describes the histologic (cell) type and behavior of this primary. First locate the morphology code in the Alphabetic Index (pages 105 – 218). Then locate the specific morphology code in the Morphology of Neoplasms – Numerical List section (pages 69 – 104). Follow the coding rules outlined in *ICD-O-3* on pages 20 – 40.

   ***Note:** *ICD-O-3* is effective for cases diagnosed January 1, 2001 forward. Continue to use *ICD-O-2* for cases diagnosed prior to 2001.

b. In the Alphabetic Index, all morphology codes are identified by an M- preceding the code number. Do not record the M on the abstract. Do not record the virgule (/ - slash) on the abstract.

   Example: Infiltrating duct carcinoma is code M-8500/3. Record code 85003.

c. Review all pathology reports that describe the primary site before coding histology and behavior. Read each pathology report in its entirety. Although the report from the definitive cancer-directed surgery is usually the best source, sometimes all of the positive tissue is removed at biopsy.

   Example: The pathology report from a skin biopsy states malignant melanoma, NOS. At wide excision, no residual tumor was found. Code the histology from the biopsy report as malignant melanoma, NOS (8720/3).

d. If no tissue or cytology specimen was obtained for a diagnosis of malignancy, but a recognized medical practitioner makes a clinical diagnosis of cancer, malignancy, malignant tumor, or malignant neoplasm, code to 8000/3 (Neoplasm, malignant). If the physician is more specific, use the more specific morphology code.

   The codes for cancer, NOS (8000/3) and carcinoma, NOS (8010/3) are not interchangeable. If the physician says that the patient has carcinoma, code carcinoma, NOS (8010/3).

BEHAVIOR

Item Length: 1
Data Type: Numeric
ACoS: Required
State Registry: Required

NAACCR Item #523

Description
The fifth digit, which follows the slash after the histology code, is the behavior code. Behavior codes are listed in *ICD-O-3* page 66 and below. The State Cancer Registry requires only tumors ending in a fifth digit behavior code of /2 or /3 to be reported.

Note: *ICD-O-3* is effective for cases diagnosed January 1, 2001 forward. Continue to use *ICD-O-2* for cases diagnosed prior to 2001.

Codes
/0 Benign (do not report to State Registry)

Exception:
Benign neoplasms of the brain and central nervous system diagnosed January 1, 2004 or later should be reported.

/1 Borderline (do not report to State Registry)
Uncertain whether benign or malignant
Borderline malignancy
Low malignant potential

Exceptions:
Pilocytic/juvenile astrocytoma, listed as 9421/1 in ICD-O-3, is required and should be reported as 9421/3 unless primary site is optic nerve which should be reported as non-malignant if diagnosed 2004 or later; **Updated: As of 01/01/2023-** Pilocytic/juvenile astrocytoma is reported a behavior /1 Borderline neoplasms of the brain and central nervous system diagnosed January 1, 2004 or later should be reported.

/2 Carcinoma in situ (report to State Registry)
Intraepithelial
Noninfiltrating
Noninvasive

Exceptions: Preinvasive cervical neoplasia (in situ lesions and CIN III), prostatic intraepithelial neoplasia, grade III, and basal cell and squamous cell carcinoma of non-genital skin are not reportable if diagnosed 01/01/2003 or later.

/3 Malignant, primary site (report to State Registry)

/6 Malignant, metastatic site (do not use)
Malignant, secondary site

/9 Malignant, uncertain whether primary or metastatic site (do not use)

Instructions for Behavior Code
a. Since tumor registries include only primary, and not metastatic sites, behavior codes 6 and 9 should never be used. They are listed here for informational purposes only.

b. Behavior codes /0 (benign) and /1 (uncertain or borderline) are not reportable to the State Cancer Registry unless listed under exceptions above. However, at the discretion of the cancer committee, a hospital may choose to collect some of these cases, which are called “reportable-by-agreement.” The behavior codes are listed here for informational purposes only.

c. The behavior code /6 indicates a metastatic site. If the only specimen available for diagnosis was from a metastatic site, code the histologic type of the metastatic site and code a /3 for the behavior code.

If the primary site is known, record the applicable topography code. If the primary site is unknown, the topography code should be C80.9.

Example: If the patient had a biopsy of the lung showing metastatic adenocarcinoma (8140/6), the primary site is unknown (C80.9). Code the histology to adenocarcinoma (8140/3).

d. "In situ" is a concept based upon histologic evidence. Therefore, clinical evidence alone cannot justify the usage of this term. If the fifth digit in Histology/Behavior is coded /2 (in situ), diagnostic confirmation should be 1, 2, or 4.

The following terms are synonymous with **in situ** (fifth digit behavior code /2):

(Adeno)carcinoma in an adenomatous polyp with no invasion of stalk
AIN III – Anal intraepithelial neoplasia, grade III (C21.1, 8077/2)
Bowen disease (8081/2)
CIN III – Cervical intraepithelial neoplasia, grade III (C53._, 8077/2)
Clark's Level 1 for melanoma (limited to epithelium)
Comedocarcinoma, noninfiltrating (C50._, 8501/2)
Confined to epithelium
High grade dysplasia in the gastrointestinal (GI) tract
(Confirm that the pathologist uses "high grade dysplasia" for in situ in the GI tract.)
Hutchinson melanotic freckle, NOS (C44._, 8742/2)
Intracystic, noninfiltrating (carcinoma)
Intraductal (carcinoma)
Intraductal oncocytic papillary neoplasm, NOS (8455/2)
Intraepidermal, NOS (carcinoma)
Intraepithelial, NOS (carcinoma)
Involvement up to but not including the basement membrane
Lentigo maligna (C44._, 8742/2)
Lobular neoplasia (C50._)
Lobular, noninfiltrating (C50._, 8520/2) (carcinoma)
Noninfiltrating (carcinoma)
Noninvasive (carcinoma only)
No stromal involvement or invasion (If there is stromal invasion, it is not in situ.)
Papillary, noninfiltrating or intraductal (carcinoma)
Precancerous melanosis (C44._, 8741/2)
PIN III – Prostatic intraepithelial neoplasia, grade III (C61.9, 8148/2)
Queyrat erythroplasia (C60._, 8080/2)
AJCC Stage 0
VAIN III – Vaginal intraepithelial neoplasia, grade III (C52.9, 8077/2)
VIN III – Vulvar intraepithelial neoplasia, grade III (C51._, 8077/2)
Low-grade appendiceal mucinous neoplasm (LAMN) (8480/2, 1/1/2022 + only)
High-grade appendiceal mucinous neoplasm (HAMN) (8480/2, 1/1/2022 + only)
Intestinal-type adenoma, high grade (8144/2, C16.0-C16.9, C17.0-C17.9, Stomach and Small Intestine 1/1/2022 + only)
Serrated dysplasia, high grade (8213/2, C16.0-C16.9, C17.0-C17.9, Stomach and Small Intestine 1/1/2022 + only)

e. Code behavior as malignant (/3) if any malignant invasion is present, no matter how limited. Any pathologic diagnosis qualified as "microinvasive" is not considered "carcinoma in situ" and behavior should be coded as malignant (/3).

Example: The pathology report from a hysterectomy reads "carcinoma in situ (8010/2) of the cervix with microinvasion." Code to invasive carcinoma (8010/3).

f. Code behavior as malignant (/3) if any malignant metastasis to nodes or tissue beyond the primary is present.

g. Gastro-intestinal stromal tumors (GIST) and thymomas are frequently non-malignant. However, they must be assigned a behavior code of 3 and abstracted if they have multiple foci, metastasis or positive lymph nodes.*(All GISTs are reported as malignant (behavior /3) for 2021+ diagnosis year).*

SCHEMA ID

Item Length: 5
ACoS: Derived
State Registry: Derived

NAACCR Item #3800

Description

Schema ID (item # 3800) will be derived by registry software based on site and histology codes entered by the registrar. For cases diagnosed 2018 and later, Schema ID is used to link all combinations of sites and histologies with the appropriate stage data collection systems, grade tables, and site-specific data items (SSDI).

GENERAL RULES FOR CODING GRADE

Grade Data Items
For cases diagnosed 01/01/2018 and forward grade will be coded in three different data items that replace the historical grade/differentiation item and the Site-Specific Factors for sites with alternative grading systems (e.g., Bloom-Richardson score for breast and Gleason score for prostate).

Grade Clinical: The grade of a solid primary tumor before any treatment.

Grade Post-Therapy Clinical: The grade of a solid primary tumor that has been microscopically sampled following neoadjuvant therapy. (01/01/2021 and forward)

Grade Pathological: The grade of a solid primary tumor that has been resected and for which no adjuvant therapy was administered.

Grade Post-Therapy Path: The grade of a solid primary tumor that has been resected following neoadjuvant therapy.

Hematopoietic and Lymphoid Neoplasms (9590/3-9993/3)
For cases diagnosed 01/01/2018 and forward, cell lineage indicator/grade (B-cell, T-cell, Null cell, K-cell) will no longer be collected for hematopoietic and lymphoid neoplasms.

Use code 8 (not applicable) in the three grade fields for all cases with histologies 9590/3-9993/3, except for Lymphoma Ocular Adnexa.

Use Grade Table #23 for the Lymphoma Ocular Adnexa cases described below.

Primary sites: C44.1, C69.0, C69.5, C69.6
Histologies: 9690/3, 9691/3, 9695/3, 9698/3

Use code 9 for all other histologies collected in the Lymphoma Ocular Adnexa chapter 71 of the AJCC manual.

Solid Tumors
a. The grade codes and instructions depend on the type of cancer (schema-specific for site and/or histology). The 2018 Grade Manual must be used to access the schema-specific grade tables and instructions at https://www.naaccr.org/SSDI/Grade-Manual.pdf.

   Once the Schema ID has been derived, based on site and histology-specific factors, the software may identify the correct options for coding grade. In the WEBPLUS system, the options are shown by clicking the SSDI button at the bottom of the screen and using the “look-up” feature.

b. The grade codes have been revised to include numeric and alphabetic codes in grade tables that vary by site-specific schema. The schema-specific tables will include some combination of the codes and descriptions listed in the template below.

Template for Grade Codes

Code	Grade Description
1	Site-Specific grade system category
2	Site-Specific grade system category
3	Site-Specific grade system category
4	Site-Specific grade system category
5	Site-Specific grade system category
L	Low grade
H	High grade
M	Site-Specific grade system category

Code	Grade Description
S	Site-Specific grade system category
A	Well differentiated
B	Moderately differentiated
C	Poorly differentiated
D	Undifferentiated and anaplastic
8	Not applicable (hematopoietic neoplasm only)
9	Grade cannot be assessed; unknown
Blank	(Post-therapy only.)

- Codes 1-5 are applicable for the AJCC-recommended grading systems. Not all tables will have 5 codes.
- Codes L and H are used for cancers where “low grade” and “high grade” are applicable, e.g., urinary cancers with urothelial histologies.
- Codes A-D are the generic grade categories used historically and are still applicable where there is no preferred grading system, the recommended grading system is not documented, or there is no AJCC chapter for the primary site. Codes A-D are not available for all cancers.

c. Code the grade from the primary tumor only, not from a metastatic site or recurrence.
   - If the tumor extends contiguously to an adjacent site and tissue is not available from the primary site, code grade from the adjacent site.
   - If the primary site is unknown, code grade to 9.

d. If there is more than one grade documented for one of the grade data items, code the grade according to the priority order specified in schema-specific instructions. If there is no priority order specified, code the highest grade.

e. Code grade from the invasive component if there are invasive and in situ components present.

f. Code grade for an insitu only tumor if it is documented. Do not code grade for dysplasia, such as high-grade dysplasia.

GRADE CLINICAL

Item Length: 1
ACoS: Required
State Registry: Required

NAACCR Item #3843

Description
This is a required 1-character field to record the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant).

For cases diagnosed January 1, 2018 and later this data item, with Grade Pathology and Grade Post-Therapy Path, replaces the historical grade/differentiation item and the Site-Specific Factors for sites with alternative grading systems (e.g., Bloom-Richardson score for breast and Gleason score for prostate).

General Instructions
1. Code Clinical Grade for cases where histological (microscopic) exam is performed on primary tumor tissue and the grade is documented. This includes FNA, biopsy, needle core biopsy, etc.

   Once the Schema ID has been derived, based on site and histology-specific factors, the software may identify the correct options for coding grade. In the WEBPLUS system, the options are shown by clicking the SSDI button at the bottom of the screen and using the "look-up" feature.

2. Assign the highest grade from the primary tumor assessed during the clinical time frame.

3. Use code 9 (unknown) when
   - Grade is not documented
   - Clinical staging is not applicable (e.g., cancer is an incidental finding during surgery for another condition)
   - Grade is checked "not applicable" on CAP Protocol and no other grade information is available.

4. If there is only one grade available and it cannot be determined if it is clinical or pathological, assign the clinical grade appropriately, code unknown (9) for pathological grade, and leave the post-therapy grade blank.

5. Clinical grade must not be blank.

Refer to the site-specific Grade Clinical tables for detailed instructions.

GRADE POST-THERAPY CLINICAL (yc)

NAACCR Item #1068

Item Length: 1
Data Type: Numeric
ACoS: Required
State Registry: Required

Description
This is a required 1-character field to record the grade of a solid primary tumor that has been microscopically sampled following neoadjuvant therapy.

For cases diagnosed January 1, 2021 and later this data item, with Grade Clinical, Grade Pathological, Grade Post-therapy Path replaces the historical grade/differentiation item and the Site-Specific Factors for sites with alternative grading systems (e.g., Bloom-Richardson score for breast and Gleason score for prostate).

General Instructions
1. Assign the highest grade documented from the microscopically sampled primary tumor assessed after completion of neoadjuvant therapy.

   Once the Schema ID has been derived, based on site and histology-specific factors, the software may identify the correct options for coding grade. In the WEBPLUS system, find the options by clicking the SSDI button at the bottom of the screen and using the “look-up” feature.

2. Leave post-therapy clin grade blank when
   - There is no neoadjuvant therapy
   - Clinical or pathological case only
   - There is only one grade available, and it cannot be determined if it is clinical, pathological or post-therapy.

3. Use code 9 (unknown) when
   - Primary site is sampled after neoadjuvant therapy and grade from the primary site is not documented
   - Grade is checked “not applicable” on CAP Protocol and no other grade information is available.
   - Primary site is sampled after neoadjuvant therapy and there is no residual cancer.

Refer to the site-specific Grade Post-Therapy Clin tables for detailed instructions.

GRADE PATHOLOGICAL

Item Length: 1
ACoS: Required
State Registry: Required

NAACCR Item #3844

Description
This is a required 1-character field to record the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy has been administered. This may include the grade from the clinical workup.

For cases diagnosed January 1, 2018 and later this data item, with Grade Clinical and Grade Post-Therapy replaces the historical grade/differentiation item and the Site-Specific Factors for sites with alternative grading systems (e.g., Bloom-Richardson score for breast and Gleason score for prostate).

General Instructions
1. Assign the highest grade documented from microscopic examination of tissue from the primary tumor, whether from the clinical workup or the surgical resection.

   Once the Schema ID has been derived, based on site and histology-specific factors, the software may identify the correct options for coding grade. In the WEBPLUS system, the options are shown by clicking the SSDI button at the bottom of the screen and using the "look-up" feature.

2. If the clinical grade is the highest grade documented, use the grade identified during the clinical time frame for both the clinical grade and the pathological grade.

3. Use code 9 (unknown) when
   - Grade is not documented
   - There is no resection of the primary site
   - Neoadjuvant therapy was given before the resection (see Post-Therapy Grade)
   - Clinical case only (see Clinical Grade)
   - There is only one grade available, and it cannot be determined if it is clinical or pathological
   - Grade is checked "not applicable" on CAP Protocol and no other grade information is available

4. Pathological grade must not be blank.

5. If there is a preferred grading system for the primary site and the clinical grade uses the preferred grading system and the pathologic grade uses a non-preferred grading system, do not record the clinical grade in the pathologic grade field, enter.

Example: Biopsy of primary site shows a moderately differentiated adenocarcinoma. The surgical resection states a high grade adenocarcinoma. Grade Clinical: Grade 2 if Moderately Differentiated is the preferred grading system. Grade Pathological: Grade 9 since the preferred grading system was not used and the Generic Grade Categories do not apply to this grade table.

Refer to the site-specific Grade Pathological tables for detailed instructions.

GRADE POST-THERAPY PATH (yp)

NAACCR Item #3845

Item Length: 1
Data Type: Numeric
ACoS: Required
State Registry: Required

Description
This is a required 1-character field to record the grade of a solid primary tumor that has been resected following neoadjuvant therapy.

For cases diagnosed January 1, 2018 and later this data item, with Grade Clinical and Grade Pathological, replaces the historical grade/differentiation item and the Site-Specific Factors for sites with alternative grading systems (e.g., Bloom-Richardson score for breast and Gleason score for prostate).

General Instructions
1. Assign the highest grade documented from the surgically resected primary tumor assessed after completion of neoadjuvant therapy.

   Once the Schema ID has been derived, based on site and histology-specific factors, the software may identify the correct options for coding grade. In the WEBPLUS system, find the options by clicking the SSDI button at the bottom of the screen and using the "look-up" feature.

2. Leave post-therapy path grade blank when
   - There is no neoadjuvant therapy
   - Clinical or pathological case only
   - There is only one grade available and it cannot be determined if it is clinical, pathological or post-therapy.

3. Use code 9 (unknown) when
   - Surgical resection is done after neoadjuvant therapy and grade from the primary site is not documented
   - Grade is checked "not applicable" on CAP Protocol and no other grade information is available.
   - Surgical resection is done after neoadjuvant therapy and there is no residual cancer.

Refer to the site-specific Grade Post-Therapy Path tables for detailed instructions.

Lymphovascular invasion

Item Length: 1
Data Type: Numeric
ACoS: Required
State Registry: *Required

NAACCR Item #1182

*required if available for cases diagnosed 01/01/2012 and later.
Use past coding manuals for cases diagnosed prior to 2018.

Description
This is a required 1-character field to record a code that indicates the presence or absence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as documented from the microscopic examination by the pathologist.

Other names for lymphovascular invasion are lvi, vascular invasion, blood vessel invasion, angiolymphatic invasion, and lymphatic invasion. It does not include perineural invasion and is not the same as direct tumor extension from the primary tumor into adjacent blood vessels or involvement of regional lymph nodes.

Codes
0 lymphovascular invasion stated as not present (is absent)
1 lymphovascular invasion present or identified (not used for thyroid and adrenal)
2 lymphatic and small vessel invasion only (l) or lymphatic invasion only (thyroid and adrenal only)
3 venous (large vessel) invasion only (v) or angioinvasion (thyroid and adrenal only)
4 both lymphatic and small vessel and venous (large vessel) invasion or both lymphatic and angioinvasion (thyroid and adrenal only)
8 not applicable.
9 unknown or indeterminate/not mentioned in path report.

Instructions (use past coding manuals for cases diagnosed prior to 2018.)
1. Code from documentation in the following priority order:
   - College of american pathologist (cap) synoptic report or checklist
   - Pathology report
   - Physician's statement

2. Code from documentation for any specimen from the primary tumor. (biopsy or resection)

3. Do not code perineural invasion in this field.

4. Assign code 0:
   - If the pathology report indicates no lymphovascular invasion was identified;
   - For in situ carcinoma. In situ carcinomas have no biological access to lymphatic or vascular channels below the basement membrane.
   - When there is no residual tumor found after neoadjuvant treatment and there is no lvi on biopsy

5. Assign code 1 if lymphovascular invasion (or one of its synonyms) is documented as present in a primary tumor specimen.

   Synonyms include, but are not limited to:
   - Angiolymphatic invasion
   - Blood vessel invasion
   - Lymph vascular emboli
   - Lymphatic invasion
   - Vascular invasion

6. For case treated with neoadjuvant therapy, use the table below to code lvi unless medical record documentation conflicts with the table. Then use the medical record documentation to code lvi.

Lvi on pathology report **prior** to neoadjuvant therapy	Lvi on pathology report **after** neoadjuvant therapy	Code lvi
0 not present	0 not present	0 not present

Lvi on pathology report **prior** to neoadjuvant therapy	Lvi on pathology report **after** neoadjuvant therapy	Code lvi
0 not present	1-4 present/identified	1-4 present/identified
0 not present	9 unknown/indeterminate	9 unknown/indeterminate
1-4 present/identified	0 not present	1-4 present/identified
1-4 present/identified	1-4 present/identified	1-4 present/identified
1-4 present/identified	9 unknown/indeterminate	1-4 present/identified
9 unknown/indeterminate	0 not present	9 unknown/indeterminate
9 unknown/indeterminate	1-4 present/identified	1-4 present/identified
9 unknown/indeterminate	9 unknown/indeterminate	9 unknown/indeterminate

7. Assign code 9 when:
   - No microscopic examination of primary site tissue was performed;
   - Lymphovascular invasion is not mentioned in the pathology report;
   - The only primary site specimen is a cytology or a fine needle aspiration;
   - The biopsy is only a very small tissue sample;
   - The pathologist indicates the specimen is insufficient to determine lymphovascular invasion;
   - It is not possible to determine whether lymphovascular invasion is present;
   - Primary site is unknown.
   - Ambiguous terminology used (example-when stated to be “suspicious lvi”)

8. Code lymphovascular invasion for the schema id’s according to the table provided below.

Code lvi 0, 1, 2, 3, 4, or 9	Code lvi 0, 1, 2, 3, 4, 8, or 9	Code lvi 8
00071: lip	00060: cervical lymph nodes, occult head and neck	00430: gist (2021+)
00072: tongue anterior	00090: nasopharynx	00710: lymphoma ocular adnexa
00073: gum	00118: pharynx other	00790: lymphoma (excluding cll/sll)
00074: floor of mouth	00119: middle ear	00795: lymphoma (cll/sll)
00075: palate hard	00128: sinus other	00811: mycosis fungoides
00076: buccal mucosa	00140: melanoma head and neck	00812: primary cutaneous lymphomas (excluding mf and ss)
00077: mouth other	00150: cutaneous squamous cell carcinoma of head and neck	00821: plasma cell myeloma
00080: major salivary glands	00210: anus	00822: plasma cell disorders
00100: oropharynx hpv-mediated (p16+)	00220: liver	00830: hemeretic
00111: oropharynx (p16-)	00241: gallbladder	
00112: hypopharynx	00242: cystic duct	
00121: maxillary sinus	00278: biliary other	
00122: nasal cavity and ethmoid sinus	00288: digestive other	
00130: larynx other	00310: net jejunum and ileum	
00131: larynx supraglottic	00358: trachea	
00132: larynx glottic	00370: pleural mesothelioma	
00133: larynx subglottic	00378: respiratory other	
00161: esophagus (including ge junction) squamous	00381: bone appendicular skeleton	
00169: esophagus (including ge junction) (excluding squamous)	00382: bone spine	
	00383: bone pelvis	
00170: stomach	00400: soft tissue head and neck	
00180: small intestine	00410: soft tissue trunk and extremities	
00190: appendix	00421: soft tissue abdomen and thorax	
00200: colon and rectum	00422: heart, mediastinum, and pleura	
00230: bile ducts intrahepat	00430: gist (2018-2020)	
00250: bile ducts perihilar	00440: retroperitoneum	
00260: bile duct distal	00450: soft tissue other	
00270: ampulla of vater	00458: kaposi sarcoma	
00280: pancreas		
00290: net stomach		
00301: net duodenum		

Code lvi 0, 1, 2, 3, 4, or 9	Code lvi 0, 1, 2, 3, 4, 8, or 9	Code lvi 8
00302: net ampulla of vater 00320: net appendix 00330: net colon and rectum 00340: net pancreas 00350: thymus 00360: lung 00460: merkel cell skin 00470: melanoma skin 00500: vulva 00510: vagina 00520: cervix 00530: corpus carcinoma and carcinosarcoma 00541: corpus sarcoma 00542: corpus adenosarcoma 00560: placenta 00570: penis 00590: testis 00620: bladder 00730: thyroid 00740: thyroid medullary	00478: skin other 00480: breast (invasive) 00551: ovary 00552: primary peritoneal carcinoma 00553: fallopian tube 00558: adnexa uterine other 00559: genital female 00580: prostate 00598: genital male other 00600: kidney parenchyma 00610: kidney renal pelvis 00631: urethra 00633: urethra-prostatic 00638: urinary other 00640: skin eyelid 00650: conjunctiva 00660: melanoma conjunctiva 00671: melanoma iris 00672: melanoma choroid and ciliary body 00680: retinoblastoma 00690: lacrimal gland 00698: lacrimal sac 00700: orbital sarcoma 00718: eye other 00721: brain 00722: cns other 00723: intracranial gland 00750: parathyroid 00760: adrenal gland 00770: net adrenal gland 00778: endocrine other 99999: ill-defined other	

DESCRIPTION OF DIAGNOSIS
WEBPLUS Items:
Primary Site Title, Histology Title, Dx Procedure Pathology

Data Type: Text
ACoS: N/A
State Registry: Required

Description
This is a required text field in the paper abstract and the corresponding required WEBPLUS fields for recording a narrative description of the primary site, histologic type, behavior, and grade. Facilities using other types of registry software should follow their vendor's instructions for recording text about the site and histology. *ISCR will no longer accept paper abstracts beginning 1/1/2026

Rationale
Text is needed to justify the codes selected for the data items and to record information that is not coded at all. The text is used for quality control and special studies.

Instructions
a. Record a brief, but specific, description of the site of origin for the tumor being reported. Include laterality if applicable. Use standard abbreviations to conserve space if necessary and if each abbreviation has a clear meaning and only one interpretation.

   Example 1: Upper outer quadrant (UOQ) of right (RT) breast.
   Example 2: Splenic flexure of colon.

b. Record a brief, but specific, description of the histologic type, behavior, and grade of the tumor being reported. Use standard abbreviations to conserve space if necessary and if each abbreviation has a clear meaning and only one interpretation. *(For 2018+ diagnosis year: Grade may be specified by Clinical or CGR, Pathological or PGR, Post Therapy Pathologic or yPGR, Post Therapy Clinical or yCGR)*

   Example 1: Infiltrating ductal ca. CGR-2, PGR-9, yPGR-2
   Example 2: Invasive Mucinous Adenoca, CGR 2, PGR 3

c. In the Description of Diagnosis or the WEBPLUS Dx Procedure Pathology field, record any additional pertinent information from cytology and histopathology reports. In WEBPLUS it is not necessary to repeat information recorded in the primary site and histology text fields. Include, as applicable:

   Date(s) of procedure(s)
   Type(s) of tissue specimen(s)
   Gross tumor size
   Extent of tumor spread
   Involvement of resection margins
   Information regarding lymphovascular invasion (LVI)
   Number of lymph nodes involved and examined
   Differential diagnoses considered and any ruled out or favored.

d. Facilities using paper abstracts to report should also **attach copies of medical record documentation** (such as pathology reports and operative reports) that identifies the site and histology information for the primary being reported. However, text describing the site and histology must be completed by all reporting facilities. *ISCR will no longer accept paper abstracts beginning 1/1/2026

TUMOR SIZE SUMMARY

Item Length: 3
Data Type: Numeric
Right Justified, Zero Fill
ACoS: Required*
State Registry: Required*

NAACCR Item #756

*For cases diagnosed 01/01/2016 and later.

Description
This is a required 3-character field to record the most accurate measurement of a solid primary tumor. Right justify and enter leading zeros.

Note: Code this data item for cases diagnosed on or after January 01, 2016. For cases diagnosed January 1, 2004 through December 31, 2015, code tumor size using *CS Tumor Size.*

Codes

000	No mass or tumor found; e.g., a tumor of a stated primary site is not found, but the tumor has metastasized.
001	1 mm or described as less than 1 mm
002-988	Exact size in millimeters (2 mm to 988 mm)
989	989 millimeters or larger
990	Microscopic focus or foci only and no size is given.
998	Tumor involvement of specified esophageal, stomach, colorectal, lung and main stem bronchus, and breast primaries. (Avoid coding tumor size based on a description such as "Mass was present at 22 to 25cm." Descriptions like this are found on endoscopies. Look for an actual measurement of the mass or stated tumor size.)
999	Unknown; size not stated; not documented in the patient record; size of tumor cannot be assessed; not applicable.

Priority Order for Recording Tumor Size

a. Record the size measured on the surgical resection specimen when surgery is performed as the first definitive treatment. No pre-surgical treatment has been given.

b. If neoadjuvant therapy was given before surgery, do not record the size of the pathologic specimen. Code the largest size of the tumor documented prior to neoadjuvant therapy. If size is unknown, record code 999.

c. If there's no surgical resection of the primary tumor, record the largest measurement of the tumor from documentation of physical exam, imaging, or other diagnostic procedures performed prior to any other form of treatment.

d. If a, b, and c above do not apply, record the largest size from all information available within four months of the date of diagnosis, in the absence of disease progression.

Instructions

a. Record the diameter of the tumor as tumor size, not the depth or thickness.

b. Record the size of the invasive component, if stated.
   (1) If both an in situ and an invasive component are present and the invasive component is stated, record the size of the invasive component even if it is smaller.

   (2) If the size of the invasive component is not stated, record the size of the entire tumor.

c. For purely in situ tumors, record the size as stated.

d. Code the size of the primary tumor, rather than the size of the specimen, polyp, ulcer, cyst, or distant metastasis. However, if the tumor is described as a "cystic mass," and only the size of the entire mass is stated, code the size of the entire mass, since the cysts are part of the tumor itself.

e. Recording less than/greater than tumor size:

(1) If tumor size is reported as less than "x" mm or less than "x" cm, record tumor size as 1mm less than "x." For example:
Size of <10 mm, code as 009
Size of < 1 cm, code as 009
Size of < 2 cm, code as 019
Size of < 3 cm, code as 029
Size of < 1 mm, code as 001

(2) If tumor size is reported as more than "x" mm or more than "x" cm, record tumor size a 1 mm more than "x." For example:
Size of >10 mm, code as 011
Size of > 1 cm, code as 011
Size of > 2 cm, code as 021
Size of > 3 cm, code as 031
Size of > 989 mm (98.9 cm), code as 989

(3) If tumor size is reported be between two sizes, record tumor size as the midpoint between the two by adding the two together and dividing by two. For example:
Size of between 2 and 3 cm, code as 025

f. Rounding and Converting
(1) If tumor size is greater than 1 millimeter and described in fractions of millimeters:
Round tenths of mm in the 1-4 range down to the nearest whole millimeter (e.g., code 5.2 mm to 005),
Round tenths of mm in the 5-9 range up to the nearest whole millimeter (e.g., code 6.5 mm to 007).

(2) If tumor size is described in centimeters, move the decimal one space to the right, converting the measurement to millimeters (e.g., code 1.5 cm to 015).

g. Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.

Example: Anal canal tumor is 2.5cm from proximal to distal (3.5cm in circumference). Record tumor size as 035)

h. Disregard microscopic residual or positive surgical margins when coding tumor size.

i. Discrepancies
(1) If there are discrepancies among tumor size measurements in the various sections of the pathology report, code the size from the synoptic report (CAP protocol or pathology report checklist). If only a text report is available, use: final diagnosis, microscopic, or gross examination, in that order.
(2) If there is a difference in reported tumor size among imaging and radiographic techniques, unless the physician specifies which imaging is most accurate, record the largest size in the record, regardless of which imaging technique reports it.

j. Do not add the size of pieces or chips together to create a whole as they may not be from the same location, or they represent only a small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size. If the only measurement describes pieces or chips, record tumor size as 999.

k. If the tumor is multi-focal or if multiple tumors are reported as a single primary, code the size of the largest invasive tumor. If all of the tumors are in situ, code the size of the largest in situ tumor.

l. Record **998** when the following terms describe tumor involvement in these specific sites:
- Esophagus (C15.0 – C15.9) Entire circumference
- Stomach (C16.0 – C16.9) Diffuse; widespread; 3/4 or more; linitis plastica

- Colorectal (C18.0, C18.2 – C20.9) Familial/multiple polyposis
- Lung and main stem bronchus (C34.0 – C34.9) Diffuse, entire lung, or NOS
- Breast (C50.0 – C50.9) Diffuse

m. Record **999** for the following (size is unknown or not applicable):

- Tumor size is unknown or not documented in the patient record.
- Calcifications that span given distance or a cluster of microcalcifications. Do not record the size of calcifications as tumor size. If there is no measurement of the mass or tumor, record 999 for clinical tumor.
- For the following sites and diseases:
  - Primary sites C42.0, C42.1, C42.3, C42.4, C77.0-C77.9, or C80.9
  - Hematopoietic, reticuloendothelial, myeloproliferative, and myelodysplastic diseases. (histology codes 9590-9993), excluding cases in the following schemas:
    Lymphoma ocular adnexa,
    Primary cutaneous lymphomas,
    Mycosis fungoides and lymphomas that are collected in the brain, CNS other, and intracranial gland schemas.
  - Kaposi sarcoma (9140)
  - Melanoma choroid
  - Melanoma ciliary body
  - Melanoma iris

n. Record **000** for the following schema:
Cervical lymph nodes and unknown primary (head and neck) (Schema ID 00060)

o. Document information to support coded tumor size in the appropriate text data item of the abstract.

REGIONAL NODES POSITIVE

Item Length: 2
Data Type: Numeric
Right Justified, Zero Fill
ACoS: Required
State Registry: Required

NAACCR Item #820

Description
This is a required 2-character field to record the number of regional lymph nodes the pathologist examined and described as metastatic, or positive for malignancy. For numbers less than 10, enter a leading zero.

Codes
00 All regional nodes examined are negative.
01-89 1-89 regional nodes are positive. Code exact number of nodes positive.
90 90 or more regional nodes are positive.
95 Positive aspiration or core biopsy of regional lymph node(s) was performed. Use when positive lymph node is aspirated, and surgically resected lymph nodes are negative.
97 Positive regional lymph nodes are documented, but the number is unspecified.
98 No regional nodes were examined.
99 It is unknown whether nodes are positive; not applicable; not stated in the patient record.

Example: The pathology report reads 11 out of 17 nodes examined were found to contain metastatic squamous cell carcinoma. Record 11 in the *Regional Nodes Positive* field.

Instructions
a. Record the total number of regional lymph nodes removed as part of the first course of treatment, examined by the pathologist, and reported to contain cancer. The number of regional lymph nodes positive is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.

- Do not record positive *distant* lymph nodes removed as part of the first course of treatment.
- Do not code positive regional lymph nodes removed to establish recurrence or progression of disease.
- Do not code nodes assessed by clinical examination only and stated to be positive.

b. Record the number positive regardless of whether the patient received preoperative treatment.

c. Since true in situ cases cannot have positive lymph nodes, the only allowable codes are 00 (negative) or 98 (not examined). Codes 01-97 and 99 are not allowed for in situ cases.

d. Use code 99 for the following primary sites and histologies or schemas:

- C42.0, C42.1, C42.3, C42.4, C58.9, C70.0-C70.9, C71.0-C72.9, C75.1-C75.3, C76.1-C76.8, C77.0-C77.9, or C80.9
- Placenta
- Brain and cerebral meninges
- Other parts of central nervous system
- Intracranial gland
- Hodgkin and non-Hodgkin lymphoma (excludes the following schemas: Lymphoma Ocular Adnexa, Primary Cutaneous Lymphomas and Mycosis Fungoides)
- Hematopoietic, reticuloendothelial, immunoproliferative, myelodysplastic or myeloproliferative neoplasms
- Myeloma and plasma cell disorders (excludes histology 9734)
- Other and ill-defined primary sites (excludes spleen – C42.2)
- Unknown primary site

e. “Lymphatic invasion” means that tumor was found in lymph channels, but does not necessarily mean that the lymph node was invaded. It is a prognostic indicator, however, since it indicates that the tumor is present in the pathway by which it spreads.

REGIONAL NODES EXAMINED

Item Length: 2
Data Type: Numeric
Right Justified, Zero Fill
ACoS: Required
State Registry: Required

NAACCR Item #830

Description
This is a required 2-character field to record the total number of regional lymph nodes that were examined by a pathologist. For numbers less than 10, enter a leading zero.

Codes
00 No regional lymph nodes were examined.
01-89 1-89 regional lymph node(s) were examined. Code the exact number of regional lymph nodes examined.
90 Ninety or more regional lymph nodes were examined.
95 No regional lymph node(s) were removed but aspiration or core biopsy of regional lymph node(s) was performed.
96 Regional lymph node removal was documented as a sampling and the number of lymph nodes is unknown/not stated.
97 Regional lymph node removal was documented as a dissection and the number of lymph nodes is unknown/not stated.
98 Regional lymph nodes were surgically removed but the number of lymph nodes unknown/not stated and not documented as sampling or dissection; nodes were examined but the number is unknown.
99 It is unknown whether nodes were examined; not applicable or negative; not stated in the patient record.

Instructions
a. Record the total number of regional lymph nodes removed as part of the first course of treatment and examined by the pathologist. The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.

- Do not record *distant* lymph nodes removed as part of the first course of treatment.
- Do not code regional lymph nodes removed to establish recurrence or progression of disease.
- Do not code nodes assessed by clinical examination. The statement, “the neck was negative for nodes,” should be interpreted (coded) as “no nodes examined.”
- If FNA of a regional lymph node was positive (95) during clinical workup, but dissection of all nodes are microscopically negative at resection, code the number of nodes removed at resection (do not include same lymph node biopsied if in same regional node chain in the total count).

b. Record the number examined regardless of whether the patient received preoperative treatment.

c. Use code 99 for the following primary sites and histologies or schemas:
- C42.0, C42.1, C42.3, C42.4, C58.9, C70.0-C70.9, C71.0-C72.9, C75.1-C75.3, C76.1-C76.8, C77.0-C77.9, or C80.9
- Placenta
- Brain and cerebral meninges
- Other parts of central nervous system
- Intracranial gland
- Hodgkin and non-Hodgkin lymphoma (excludes the following schemas: Lymphoma Ocular Adnexa, Primary Cutaneous Lymphomas and Mycosis Fungoides)
- Hematopoietic, reticuloendothelial, immunoproliferative, myelodysplastic or myeloproliferative neoplasms
- Myeloma and plasma cell disorders (excludes histology 9734)
- Other and ill-defined primary sites (excludes spleen – C42.2)
- Unknown primary site

METS AT DX-BONE

NAACCR Item #1112

Item Length: 1
Data Type: Numeric
ACoS: Required*
State Registry: Required*

*For cases diagnosed 01/01/2016 and later.

Description
This is a required 1-character field to record whether bone is an involved metastatic site at the time of diagnosis.

Codes
0 None; no bone metastases
1 Yes; distant bone metastases
8 Not applicable
9 Unknown whether bone is an involved metastatic site; not documented in patient record

General Rules
a. Code this data item for all solid tumors, Kaposi sarcoma, unknown primary site, and other and ill-defined primary sites. This includes bone metastases occurring in the following hematopoietic diagnoses (schemas):
   - Lymphoma ocular adnexa — schema 00710
   - Lymphoma (excluding CLL/SLL) (excluding primary sites C77.0-C77.9) — schema 00790
   - Lymphoma (CLL/SLL) (excluding primary sites C77.0-C77.9) — schema 00795
   - Mycosis fungoides — schema 00811
   - Primary cutaneous lymphoma (excluding MF and SS) — schema 00812
   - HemeRetic (excluding primary sites C420, C421, C423, C424) — schema 00830

b. Code information about discontinuous or distant metastases to bone only identified at the time of diagnosis. Bone involvement may be single or multiple.

c. Do not code this data item for bone marrow involvement.

d. Use clinical and/or pathologic information about bone involvement.

e. Code this data item for bone metastasis even if the patient received preoperative systemic therapy.

Instructions
a. Use code 0 when the medical record:

   (1) Indicates that there are no distant (discontinuous) metastases at all;

   (2) Confirms the tumor is benign (/0), borderline (/1) or in situ (/2);

   (3) Includes a clinical or pathologic statement that there are no bone metastases;

   (4) Includes imaging reports that are negative for bone metastases;

   (5) Indicates that the patient has distant (discontinuous) metastases but bone is not mentioned as an involved site.

b. Use code 1 when the medical record:

   (1) Indicates that the patient has distant (discontinuous) metastases and bone is mentioned as an involved site;

   (2) Indicates that bone is the primary site and there are metastases in a <u>different</u> bone or bones (<u>not</u> for multifocal bone involvement of the same bone);

(3) Indicates that the patient is diagnosed as an unknown primary (C80.9) and bone is mentioned as a distant metastatic site.

c. Use code 8 (not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant:

ICD-O-3 Site	ICD-O-3 Histology	Description
C000-C809	9740-9809 9840-9993	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420 C421 C424	9811-9818 9823 9827 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440 C442-C689 C691-C694 C698-C809	9820 9826 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440 C442-C689 C691-C694 C698-C809	9731 9732 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C420, C421, C423, C424	Any histology	*See Note

Note: Do **not** use code 8 for lymphoma histologies (9590-9699, 9702-9726, 9728-9729, 9735, 9737, and 9738) in sites other than C420, C421, C424, C770-C779. In all other sites code lymphoma like a solid tumor, use code 0, 1, or 9. See General Rules, paragraph a in this section.

d. Use code 9 when:

(1) It cannot be determined from the medical record whether the patient specifically has bone metastases;

(2) There is documentation of carcinomatosis but bone is not specifically mentioned as a metastatic site;

(3) There are known distant metastases but it is not known whether the distant metastases include bone.

METS AT DX-BRAIN

NAACCR Item #1113

Item Length: 1
Data Type: Numeric
ACoS: Required*
State Registry: Required*

*For cases diagnosed 01/01/2016 and later.

Description
This is a required 1-character field to record whether brain is an involved metastatic site at the time of diagnosis.

Codes
0 None; no brain metastases
1 Yes; distant brain metastases
8 Not applicable
9 Unknown whether brain is an involved metastatic site; not documented in patient record

General Rules
a. Code this data item for all solid tumors, Kaposi sarcoma, unknown primary site, and other and ill-defined primary sites. This includes brain metastases occurring in the following hematopoietic diagnoses (schemas):
   - Lymphoma ocular adnexa schema 00710
   - Lymphoma (excluding CLL/SLL) (excluding primary sites C77.0-C77.9) schema 00790
   - Lymphoma (CLL/SLL) (excluding primary sites C77.0-C77.9) schema 00795
   - Mycosis fungoides schema 00811
   - Primary cutaneous lymphoma (excluding MF and SS) schema 00812
   - HemeRetic (excluding primary sites C420, C421, C423, C424) schema 00830

b. Code information about discontinuous or distant metastases to brain only identified at the time of diagnosis. Brain involvement may be single or multiple.

c. Do not code this data item for involvement of spinal cord or other parts of the central nervous system.

d. Use clinical and/or pathologic information about brain involvement.

e. Code this data item for brain metastasis even if the patient received preoperative systemic therapy.

Instructions
a. Use code 0 when the medical record:

   (1) Indicates that there are no distant (discontinuous) metastases at all;

   (2) Confirms the tumor is benign (/0), borderline (/1) or in situ (/2);

   (3) Includes a clinical or pathologic statement that there are no brain metastases;

   (4) Includes imaging reports that are negative for brain metastases;

   (5) Indicates that the patient has distant (discontinuous) metastases but brain is not mentioned as an involved site.

b. Use code 1 when the medical record:

   (1) Indicates that the patient has distant (discontinuous) metastases and brain is mentioned as an involved site;

   (2) Indicates that the patient is diagnosed as an unknown primary (C80.9) and brain is mentioned as a distant metastatic site.

c. Use code 8 (not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant:

ID-O-3 Site	ICD-O-3 Histology	Description
C000-C809	9740-9809 9840-9993	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420 C421 C424	9811-9818 9823 9827 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440 C442-C689 C691-C694 C698-C809	9820 9826 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440 C442-C689 C691-C694 C698-C809	9731 9732 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C420, C421, C423, C424	Any histology	*See Note

Note: Do **not** use code 8 for lymphoma histologies (9590-9699, 9702-9726, 9728-9729, 9735, 9737, and 9738) in sites other than C420, C421, C424, C770-C779. In all other sites code lymphoma like a solid tumor, use code 0, 1, or 9. See General Rules, paragraph a in this section.

d. Use code 9 when:

(1) It cannot be determined from the medical record whether the patient specifically has brain metastases;

(2) There is documentation of carcinomatosis but brain is not specifically mentioned as a metastatic site;

(3) There are known distant metastases but it is not known whether the distant metastases include brain.

METS AT DX-DISTANT LYMPH NODES

Item Length: 1
Data Type: Numeric
ACoS: Required*
State Registry: Required*

NAACCR Item #1114

*For cases diagnosed 01/01/2016 and later.

Description
This is a required 1-character field to record whether distant lymph node(s) are an involved metastatic site at the time of diagnosis.

Codes
0 None; no distant lymph node metastases
1 Yes; distant lymph node metastases
8 Not applicable
9 Unknown whether distant lymph node(s) are an involved metastatic site; not documented in patient record

General Rules
a. Code this data item for all solid tumors, Kaposi sarcoma, unknown primary site, and other and ill-defined primary sites.

b. Code information about metastases to distant lymph node(s) only identified at the time of diagnosis. Distant lymph node involvement may be single or multiple.

c. Do not code this data item for regional lymph node involvement with the exception of lymph nodes for placenta, which are M1.

d. Use clinical and/or pathologic information about distant lymph node involvement.

e. Code this data item for distant lymph node metastasis even if the patient received preoperative systemic therapy.

Instructions
a. Use code 0 when the medical record:

(1) Indicates that there are no distant (discontinuous) metastases at all;

(2) Confirms the tumor is benign (/0), borderline (/1) or in situ (/2);

(3) Includes a clinical or pathologic statement that there are no distant lymph node metastases;

(4) Includes imaging reports that are negative for distant lymph node metastases;

(5) Indicates that the patient has distant (discontinuous) metastases but distant lymph nodes are not mentioned as an involved site.

b. Use code 1 when the medical record:

(1) Indicates that the patient has distant (discontinuous) metastases and distant lymph node(s) are mentioned as an involved site;

(2) Indicates that the patient is diagnosed as an unknown primary (C80.9) and distant lymph node(s) are mentioned as a metastatic site.

c. Use code 8 (not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant:

ID-O-3 Site	ICD-O-3 Histology	Description
C000-C809	9740-9809 9840-9993	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420 C421 C424	9811-9818 9823 9827 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440 C442-C689 C691-C694 C698-C809	9820 9826 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440 C442-C689 C691-C694 C698-C809	9731 9732 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
Any primary site		Lymphoma histologies (2021+ diagnosis years)
C420, C421, C423, C424	Any histology	

d. Use code 9 when:

(1) It cannot be determined from the medical record whether the patient specifically has distant lymph node metastases;

(2) There is documentation of carcinomatosis but distant lymph node(s) are not specifically mentioned as a metastatic site;

(3) There are known distant metastases but it is not known whether the distant metastases include distant lymph node(s).

METS AT DX-LIVER

Item Length: 1
Data Type: Numeric
ACoS: Required*
State Registry: Required*

NAACCR Item #1115

*For cases diagnosed 01/01/2016 and later.

Description
This is a required 1-character field to record whether liver is an involved metastatic site at the time of diagnosis.

Codes
0 None; no liver metastases
1 Yes; distant liver metastases
8 Not applicable
9 Unknown whether liver is an involved metastatic site; not documented in patient record

General Rules
a. Code this data item for all solid tumors, Kaposi sarcoma, unknown primary site, and other and ill-defined primary sites. This includes liver metastases occurring in the following hematopoietic diagnoses (schemas):
   - Lymphoma ocular adnexa schema 00710
   - Lymphoma (excluding CLL/SLL) (excluding primary sites C77.0-C77.9) schema 00790
   - Lymphoma (CLL/SLL) (excluding primary sites C77.0-C77.9) schema 00795
   - Mycosis fungoides schema 00811
   - Primary cutaneous lymphoma (excluding MF and SS) schema 00812
   - HemeRetic (excluding primary sites C420, C421, C423, C424) schema 00830

b. Code information about discontinuous or distant metastases to liver only identified at the time of diagnosis. Liver involvement may be single or multiple.

c. Use clinical and/or pathologic information about liver involvement.

d. Code this data item for liver metastasis even if the patient received preoperative systemic therapy.

Instructions
a. Use code 0 when the medical record:

   (1) Indicates that there are no distant (discontinuous) metastases at all;

   (2) Confirms the tumor is benign (/0), borderline (/1) or in situ (/2);

   (3) Includes a clinical or pathologic statement that there are no liver metastases;

   (4) Includes imaging reports that are negative for liver metastases;

   (5) Indicates that the patient has distant (discontinuous) metastases but liver is not mentioned as an involved site.

b. Use code 1 when the medical record:

   (1) Indicates that the patient has distant (discontinuous) metastases and liver is mentioned as an involved site;

   (2) Indicates that the patient is diagnosed as an unknown primary (C80.9) and liver is mentioned as a metastatic site.

c. Use code 8 (not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant:

ID-O-3 Site	ICD-O-3 Histology	Description
C000-C809	9740-9809 9840-9993	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420 C421 C424	9811-9818 9823 9827 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440 C442-C689 C691-C694 C698-C809	9820 9826 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440 C442-C689 C691-C694 C698-C809	9731 9732 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS1
C420, C421, C423, C424	Any histology	*See Note

Note: Do **not** use code 8 for lymphoma histologies (9590-9699, 9702-9726, 9728-9729, 9735, 9737, and 9738) in sites other than C420, C421, C424, C770-C779. In all other sites code lymphoma like a solid tumor, use code 0, 1, or 9. See General Rules, paragraph a in this section.

d. Use code 9 when:

(1) It cannot be determined from the medical record whether the patient specifically has liver metastases;

(2) There is documentation of carcinomatosis but liver is not specifically mentioned as a metastatic site;

(3) There are known distant metastases but it is not known whether the distant metastases include liver.

METS AT DX-LUNG

Item Length: 1
Data Type: Numeric
ACoS: Required*
State Registry: Required*

NAACCR Item #1116

*For cases diagnosed 01/01/2016 and later.

Description
This is a required 1-character field to record whether lung is an involved metastatic site at the time of diagnosis.

Codes
0 None; no lung metastases
1 Yes; distant lung metastases
8 Not applicable
9 Unknown whether lung is an involved metastatic site; not documented in patient record

General Rules
a. Code this data item for all solid tumors, Kaposi sarcoma, unknown primary site, and other and ill-defined primary sites. This includes lung metastases occurring in the following hematopoietic diagnoses (schemas):
   - Lymphoma ocular adnexa schema 00710
   - Lymphoma (excluding CLL/SLL) (excluding primary sites C77.0-C77.9) schema 00790
   - Lymphoma (CLL/SLL) (excluding primary sites C77.0-C77.9) schema 00795
   - Mycosis fungoides schema 00811
   - Primary cutaneous lymphoma (excluding MF and SS) schema 00812
   - HemeRetic (excluding primary sites C420, C421, C423, C424) schema 00830

b. Code information about discontinuous or distant metastases to lung only identified at the time of diagnosis. Lung involvement may be single or multiple.

c. Use clinical and/or pathologic information about lung involvement.

d. Code this data item for lung metastasis even if the patient received preoperative systemic therapy.

Instructions
a. Use code 0 when the medical record:

   (1) Indicates that there are no distant (discontinuous) metastases at all;

   (2) Confirms the tumor is benign (/0), borderline (/1) or in situ (/2);

   (3) Includes a clinical or pathologic statement that there are no lung metastases;

   (4) Includes imaging reports that are negative for lung metastases;

   (5) Indicates that the patient has distant (discontinuous) metastases but lung is not mentioned as an involved site.

b. Use code 1 when the medical record:

   (1) Indicates that the patient has distant (discontinuous) metastases and lung is mentioned as an involved site;

   (2) Indicates that lung is the primary site and there are metastases in the contralateral lung (not for multifocal involvement of the same lung):

   (3) Indicates that the patient is diagnosed as an unknown primary (C80.9) and lung is mentioned as a metastatic site.

c. Use code 8 (not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant:

ID-O-3 Site	ICD-O-3 Histology	Description
C000-C809	9740-9809 9840-9993	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420 C421 C424	9811-9818 9823 9827 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440 C442-C689 C691-C694 C698-C809	9820 9826 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440 C442-C689 C691-C694 C698-C809	9731 9732 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C420, C421, C423, C424	Any histology	*See Note

Note: Do **not** use code 8 for lymphoma histologies (9590-9699, 9702-9726, 9728-9729, 9735, 9737, and 9738) in sites other than C420, C421, C424, C770-C779. In all other sites code lymphoma like a solid tumor, use code 0, 1, or 9. See General Rules, paragraph a in this section.

d. Use code 9 when:

(1) It cannot be determined from the medical record whether the patient specifically has lung metastases;

(2) There is documentation of carcinomatosis but lung is not specifically mentioned as a metastatic site;

(3) There are known distant metastases but it is not known whether the distant metastases include lung.

METS AT DX-OTHER

Item Length: 1
Data Type: Numeric
ACoS: Required*
State Registry: Required*

NAACCR Item #1117

*For cases diagnosed 01/01/2016 and later.

Description
This is a required 1-character field to record whether other metastatic involvement (other than bone, brain, liver, lung or distant lymph nodes) exists at the time of diagnosis. Examples include, but are not limited to, the adrenal gland, bone marrow, pleura, peritoneum and skin.

Codes
0 None; no other metastases
1 Yes; distant metastases in known site(s) other than bone, brain, liver, lung or distant lymph nodes
2 Generalized metastases such as carcinomatosis
8 Not applicable
9 Unknown whether any other metastatic site; not documented in patient record

General Rules
a. Code this data item for all solid tumors, Kaposi sarcoma, unknown primary site, and other and ill-defined primary sites. This includes metastases to other sites occurring in the following hematopoietic diagnoses (schemas):
   - Lymphoma ocular adnexa schema 00710
   - Lymphoma (excluding CLL/SLL) (excluding primary sites C77.0-C77.9) schema 00790
   - Lymphoma (CLL/SLL) (excluding primary sites C77.0-C77.9) schema 00795
   - Mycosis fungoides schema 00811
   - Primary cutaneous lymphoma (excluding MF and SS) schema 00812
   - HemeRetic (excluding primary sites C420, C421, C423, C424) schema 00830

b. Code information about other metastases only (discontinuous or distant metastases) identified at the time of diagnosis. Other involvement may be single or multiple.

c. Do not code this data item for bone, brain, liver, lung or distant lymph node metastases

d. Use clinical and/or pathologic information about other involvement.

e. Code this data item for other metastasis even if the patient received preoperative systemic therapy.

f. Do not code spleen involvement for Hodgkin Lymphoma.

Instructions
a. Use code 0 when the medical record:

   (1) Indicates that there are no distant (discontinuous) metastases at all;

   (2) Confirms the tumor is benign (/0), borderline (/1) or in situ (/2);

   (3) Includes a clinical or pathologic statement that there are no other metastases;

   (4) Includes imaging reports that are negative for other metastases;

   (5) Indicates that the patient has distant (discontinuous) metastases but other sites are not mentioned as involved.

b. Use code 1 when the medical record indicates that the patient has distant (discontinuous) metastases in site(s) other than bone, brain, liver, lung or distant lymph node(s). Other sites include, but are not limited to, the adrenal gland, bone marrow, pleura, malignant pleural effusion, peritoneum and skin.

c. Use code 2 when the patient has carcinomatosis, a condition in which cancer is spread widely throughout the body or to a relatively large region of the body.

- If a patient has metastatic disease to bone, brain, liver, lung or distant lymph nodes and carcinomatosis, use code 1 for the appropriate data item (bone, brain, liver, lung, or distant nodes) and use code 2 for carcinomatosis.

- If a patient has metastatic disease to a site other than bone, brain, liver, lung or distant nodes and carcinomatosis, assign code 2 for carcinomatosis.

d. Use code 8 (not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant:

ID-O-3 Site	ICD-O-3 Histology	Description
C000-C809	9740-9809 9840-9993	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420 C421 C424	9811-9818 9823 9827 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440 C442-C689 C691-C694 C698-C809	9820 9826 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440 C442-C689 C691-C694 C698-C809	9731 9732 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C420, C421, C423, C424, C770-C779	Any histology	*See Note

Note: Do **not** use code 8 for lymphoma histologies (9590-9699, 9702-9726, 9728-9729, 9735, 9737, and 9738) in sites other than C420, C421, C424, C770-C779. In all other sites code lymphoma like a solid tumor, use code 0, 1, or 9. See General Rules, paragraph a in this section.

e. Use code 9 when:

(1) It cannot be determined from the medical record whether the patient has metastases other than bone, brain, liver, lung or distant lymph node(s);

(2) There are known distant metastases but it is not known specifically what they are.

SUMMARY STAGE 2018

Item Length: 1
Data Type: Numeric
ACoS: Required
State Registry: Required

NAACCR Item #764

Description
This is a required 1-character field for recording a code that indicates the extent of cancer spread. Refer to the *Summary Stage 2018 (SS2018) Manual* for complete guidelines on assigning Summary Stage to be coded in this field. The manual can be found at https://seer.cancer.gov/tools/ssm/.

For case diagnosed prior to 2018:
- For cases diagnosed 01/01/2001 through 12/31/2003 and 01/01/2015 through 12/31/2017 use *SEER Summary Staging Manual 2000.*
- For cases diagnosed January 1, 2004 through 2015, Summary Stage is derived from the Collaborative Staging input.
- For cases diagnosed prior to 2001, use *SEER Summary Staging Guide*, 1977.

Codes
0 In situ
1 Localized only
2 Regional by direct extension
3 Regional to lymph nodes only
4 Regional by direct extension and to lymph nodes (combination of codes 2 and 3)
7 Distant metastases/systemic disease
8 Benign/borderline (brain, CNS other, and intracranial gland only)
9 Unstaged, unknown, or unspecified

Note: Code 5 (Regional, NOS) can no longer be coded for SS2018.

Definitions and Rules
a. Summary Stage of disease is a clinical judgment of the extent of cancer spread and should include all information available through completion of surgery(ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer. Stage does not change as the disease progresses. Metastasis that is known to have developed after the original diagnosis was made should be excluded.

b. For all sites, the extent of disease is based on pathologic, operative, and clinical assessment. If there is a discrepancy between the pathology report and the operative report, the priority for assessing extent of disease is based on pathologic, operative, then clinical findings, respectively. Gross observations at surgery are particularly important when not all malignant tissue is removed. If no surgery is performed, use all diagnostic or radiological evidence and therapeutic procedures available in the medical record to determine the Summary Stage, if enough information is provided.

c. Autopsy reports are used in coding extent of disease by applying the same rules for inclusion and exclusion.

d. The terms used to describe tumor involvement are sometimes ambiguous. The SS2018 Manual General Coding Instructions lists terms that may be interpreted as tumor involvement or non-involvement.

Instructions
a. To determine the Summary Stage code, find the site-specific chapter in the *SS2018 Manual* for the applicable site and/or histology combination. Each such chapter is divided into general staging categories (localized, regional, and distant).

(1) The “Localized” category lists the layers or parts of the primary organ. If the cancer is contained within these layers, it is considered localized (code 1).

(2) The “Regional” category is divided into “Direct Extension” and “Lymph Nodes” subcategories.

- If the cancer has spread to any of the adjacent organs or sites listed in the Direct Extension subcategory, it is considered regional by direct extension (code 2).
- If the cancer has spread to the regional lymph nodes specified, it is considered regional to lymph nodes (code 3).
- If the cancer has spread to adjacent organs and to regional lymph nodes, use code 4, a combination of codes 2 and 3.

(3) The "Distant" category lists the most common, but not all, sites of distant spread for each primary site. If the cancer has spread to an organ that is not directly touching the original primary organ, it is considered distant by direct extension or metastasis (code 7).
Positive lymph nodes that are not in the region of the original primary site are considered distant lymph nodes (SS2018 code 7). Use the *SS2018 Manual* to determine if a lymph node is regional or distant. The *AJCC Cancer Staging Manual* (the TNM coding book) is also a good reference to use when determining Summary Stage, even if you do not actually assign TNM codes. The AJCC manual often lists lymph nodes that are considered regional (vs. distant lymph nodes) and includes illustrations that may clarify the various layers of an organ (e.g., colon).

b. Use code 8 for benign and borderline brain/CNS cases.

c. Use code 9 (unstaged) for unknown primaries (C80.9), even if the unknown primary has been diagnosed from a metastatic site.

Example: A patient with an unknown primary site (C80.9) has metastases in the brain and liver. Although at least one of these sites has to be a metastatic site distant from the original primary (since brain and liver are not adjacent to each other), SS2018 should be coded 9 (unknown). Metastatic sites for unknown primaries should be documented in the "Mets at Diagnosis" data items and the "Substantiate Stage" text item.

d. Use code 9 if the registry collects other benign/borderline tumors that are not reportable. Code 8 is allowed only for benign and borderline brain/CNS cases.

SITE-SPECIFIC DATA ITEMS (SSDI)

Item Length: variable
Data Type: Alpha & Numeric
ACoS: Required
State Registry: Required*

NAACCR Item #s 3801-3937

*Site-specific for cases diagnosed 01/01/2018 and later.

Description
For 2018, Site-Specific Data Items (SSDI) are used for collection of site-specific information. The Collaborative Stage Site-Specific Factors (CS SSFs) have been discontinued. While some of the SSDI collect the same information as the CS SSFs, the SSDI have different characteristics. Some of those differences include:

- Unique names and NAACCR data item numbers
- Field length not limited to 3 digits
- Accommodation of explicit decimal points (rather than implied)
- Different coding conventions to record actual values, percentages and ranges.

Once the schema ID has been derived, based on site and histology-specific factors, the software may identify the applicable SSDI's. In the WEBPLUS system, the applicable SSDI's are shown by clicking the SSDI button at the bottom of the screen.

The 22 SSDI listed below and briefly described are required by the State Cancer Registry. See the following link for specific codes, definitions and coding instructions: https://apps.naaccr.org/ssdi/list/

SSDI Item #3927 Schema Discriminator 2 (Oropharyngeal p16)
- Item length: 1
- Indicates whether an oropharyngeal tumor is p16 positive, p16 negative, or p16 status unknown.

SSDI Item #3926 Schema Discriminator 1 (Nasopharynx/Pharyngeal Tonsil, C11.1 only)
- Item length: 1
- Indicates whether site code C11.1 represents the posterior wall of nasopharynx, NOS; adenoid; or pharyngeal tonsil.

SSDI Item #3926 Schema Discriminator 1 (EsophagusGEJunction (EGJ)/Stomach)
- Item length: 2
- Indicates the specific location and extent of the tumor.

SSDI Item #3927 Schema Discriminator 2 (Esophagus and Esophagogastric Junction, Histology 8020/3)
- Item length: 1
- Indicates whether an undifferentiated carcinoma has a squamous component, a glandular component, or no mention of squamous or glandular component.

SSDI Item #3890 Microsatellite Instability (MSI) (Colon and Rectum)
- Item length: 1
- Records a form of genetic instability manifested by changes in the length of repeated single- to six-nucleotide sequences (known as DNA microsatellite sequences). The genetic test is performed on tumor tissue to look for differences in length of certain non-functioning sections of DNA.
- Previously collected in CS SSF# 7 for colon and rectum.

SSDI Item #3835 Fibrosis Score (Liver and Intrahepatic Bile Ducts)
- Item length: 1
- Records the degree of parenchymal fibrosis or cirrhosis (Ishak Score) of the liver based on pathological examination of the non-tumorous liver.
- Previously collected in CS SSF# 2 for liver.

SSDI Item #3926 Schema Discriminator 1 (Gallbladder, including Cystic Duct)

- Item length: 1
- Indicates whether the sub-site is distal bile duct, perihilar bile duct, or cystic duct.

SSDI Item #3926 Schema Discriminator 1 (Plasma Cell Myeloma Terminology)
- Item length: 1
- Indicates whether descriptive terms for plasma cell myeloma refer to early phases of plasma cell myeloma.

SSDI Item #3817 Breslow Tumor Thickness (Melanoma Skin)
- Item length: 4 with a decimal point in the third digit
- Records the measurement of how deeply a melanoma tumor has grown into the skin (Breslow tumor thickness or depth).
- Previously collected in CS SSF# 1 for melanoma skin.

SSDI Item #3932 LDH Lab Value
- Item length: 7 with a decimal point in the sixth digit
- Records the lab value for LDH, an enzyme released into the blood stream when cells (normal of tumor) are damaged or destroyed. It is a predictor of treatment response, progression-free survival and overall survival for patients with Stage IV melanoma of the skin.
- Previously collected in CS SSF# 5 for melanoma skin.

SSDI Item #3926 Schema Discriminator 1 (GIST Primary Peritoneum Tumor)
- Item length: 1
- Indicates the specific sub-site for GIST (gastrointestinal stromal tumor) primaries coded to C48.1.

SSDI Item #3827 Estrogen Receptor Summary (Breast)
- Item length: 1
- Records the summary of results (pathologist's interpretation) of the estrogen receptor (ER) assay.
- Previously collected in CS SSF# 1 for breast.

SSDI Item #3855 HER2 Overall Summary (Breast)
- Item length: 1
- Records the summary of results (pathologist's interpretation) from HER2 testing.
- Previously collected in CS SSF# 15 for breast.

SSDI Item #3915 Progesterone Receptor Summary (Breast)
- Item length: 1
- Records the summary of results (pathologist's interpretation) of the progesterone receptor (PR) assay.
- Previously collected in CS SSF# 2 for breast.

SSDI Item #3920 PSA (Prostatic Specific Antigen) Lab Value (Prostate)
- Item length: 5 with a decimal point in the fourth digit
- Records the PSA lab value. PSA is a protein produced by cells of the prostate gland that is elevated in patients with prostate cancer.
- Previously collected in CS SSF# 1 for prostate.

SSDI Item #3926 Schema Discriminator 1 (Urethra/Prostatic Urethra)
- Item length: 1
- Indicates whether tumors coded to C68.0 are prostatic urethra or urethra, NOS.

SSDI Item #3926 Schema Discriminator 1 (Melanoma Ciliary Body, Melanoma Iris)
- Item length: 1
- Indicates whether the sub-site is ciliary body, crystalline lens, sclera, uveal tract, intraocular, eyeball, or iris.

SSDI Item #3926 Schema Discriminator 1 (Lacrimal Gland/Sac)
- Item length: 1

- Indicates whether the sub-site is lacrimal gland, lacrimal sac, lacrimal duct NOS or nasal lacrimal duct.

SSDI Item #3816 Brain Molecular Markers
- Item length: 2
- Records molecular markers that identify clinically important brain cancer subtypes that are not distinguishable by ICD-O-3 codes.
- Applicable only for CNS histology codes: 9400/3, 9401/3, 9440/3, 9450/3, 9451/3, 9471/3 and 9478/3

SSDI Item #3926 Schema Discriminator 1 (Thyroid Gland/Thyroglossal Duct)
- Item length: 1
- Indicates whether tumors coded to C73.9 arose in the thyroid gland (thyroid, NOS) or the thyroglossal duct.

SSDI Item #3926 Schema Discriminator 1 (Occult Head and Neck Lymph Nodes)
- Item length: 1
- Indicates whether a more specific primary site code should be assigned for head and neck tumors with unknown primary site, C76.0, based on EBV and p16 status.

SSDI Item #3926 Schema Discriminator 1 (Histology Discriminator for 9591/3 Lymphoma)
- Item length: 1
- Indicates whether histology code 9591/3 is a splenic B-cell lymphoma/leukemia, unclassifiable; a hairy leukemia variant; a splenic diffuse red pulp small B-cell lymphoma; or non-Hodgkin lymphoma, NOS.

SSDI Item #3829 Esophagus and EGJ Tumor Epicenter
- Item length: 1
- Required for prognostic stage grouping for squamous and adenosquamous carcinoma in the AJCC 8th edition, Chapter 16 Esophagus and Esophagogastric Junction. It is a new data item for cases diagnosed 1/1/2018+.

SSDI Item #3838 Gleason Patterns Clinical
- Item length: 2
- Represents the Gleason primary and secondary patterns from needle core biopsy and TURP.

SSDI Item #3839 Gleason Patterns Pathological
- Item length: 2
- Represents the Gleason primary and secondary patterns from the prostatectomy or autopsy.

SSDI Item #3840 Gleason Score Clinical
- Item length: 2
- Represents the Gleason score based on adding the values for primary and secondary patterns in needle core biopsy and TURP.
-

SSDI Item #3841 Gleason Score Pathologic
- Item length: 2
- Represents the Gleason score based on adding the values for primary and secondary patterns from prostatectomy or autopsy.

SSDI Item #3842 Gleason Tertiary Pattern
- Item length: 2
- Represents the tertiary pattern value from prostatectomy or autopsy.

SSDI Item #3956 p16
- Item length: 1
- The p16 biomarker is over-expressed (produced) in response to HPV. It is therefore a surrogate marker for HPV disease. Effective for diagnosis years 01/01/2022 and forward
- Added to Anus v9 schema for cases diagnosed 01/01/2023 and forward

SSDI Item #3960 Histologic Subtype

- Item length: 1
- Applies to appendiceal tumors. LAMN, HAMN, Mucinous Adenocarcinoma, and Acinar Adenocarcinoma all have the same histology code (8480), use for distinction of histologic subtype. It is a new data items for cases diagnosed 1/1/2023+.

SSDI Item #3964 Brain Primary Tumor Location

- Item length: 1
- The Pons and other subsites of the Brain Stem have the same ICD-O topography code (C717), which is for subsites of the Brain Stem. Clinically, information regarding the Pons is very important, especially for pediatric cases. A schema discriminator is necessary to distinguish between the pons and other subsites of the brain stem. It is a new data items for cases diagnosed 1/1/2024+.

SSDI Item #1172 PTLD

- Item length: 1
- Post Transplant Lymphoproliferative Disorder-PTLD, The presence of PTLD, either polymorphic or monomorphic, has clinical significance and prognostic value, especially in the Pediatric and Adolescence and Young Adult (AYA) populations. It is a new data item for cases diagnosed 1/1/2025+.

SSDI Item #1174 PD-L1

- Item length: 5
- PD-L1 is recommended by treatment guidelines for lung cancer to determine if the patient may benefit from checkpoint inhibitor drugs (immunotherapy). It is a new data item for cases diagnosed 1/1/2025+.

SUBSTANTIATE STAGING
WEBPLUS Item: Text-Staging

Data Type: Text
ACoS: N/A
State Registry: Required

Description
This is a required text field in the paper and WEBPLUS abstracts for recording a narrative description of information that substantiates the Summary Stage and/or the AJCC staging, as applicable. It is not sufficient to merely code the items. The information from the medical record supporting the codes must be recorded. Facilities using other types of registry software should follow their vendor's instructions for recording text that substantiates staging. *ISCR will no longer accept paper abstracts beginning 1/1/2026

Instructions
a. Identify the specific evidence in the medical record that justifies the staging and record the evidence briefly, in this field. Standard abbreviations can be used to save space. It is not necessary to repeat information documented in other text fields. *Include AJCC TNM and Summary Stage (SS2018) in same text field

Examples:

Staging	Text
Summary Stage 4	SS2018-4, Small cell carcinoma of the rt. lung with extension to the pericardium and mets to 3 of 4 hilar lymph nodes.
Summary Stage 1	SS2018-1 Poorly differentiated adenocarcinoma of the sigmoid colon with invasion through the muscularis propria. LN neg.
Summary Stage 7	SS2018-7 Mucinous cystadenocarcinoma of the rt. ovary with extension to the small intestine.
Summary Stage 2	SS2018-2 Diffuse, histiocytic malignant lymphoma of the cervical and mediastinal lymph node regions. Bone marrow free of disease.
Tumor Size Summary: 005 Reg LN Pos: 00 Reg LN Exam: 20 SSDI #3817: 1.2	5 mm melanoma, 1.2 mm thick, no ulceration, 20 neg. LN, remainder of physical exam negative
AJCC TNM	Clinical AJCC 8th cT1c cN0 cM0 (GG 1, DRE neg, PSA<10) Stage 1. Pathological AJCC 8th- Unknown, no prostatectomy in 1st course.

b. Use this field to clarify any coding that is vague (e.g., specific metastatic site coded as a "9") or to justify any coding that requires the coder to override an edit error message (e.g., metastatic site coding that is consistent with AJCC staging but inconsistent with Summary Stage).

c. Document any unresolved discrepancies between physician and registry staging decisions.

d. Facilities using the paper abstract to report should also attach copies of medical record documentation (such as the pathology and operative reports) that substantiates the extent of disease. However, text that substantiates the staging must be completed by all reporting facilities. *ISCR will no longer accept paper abstracts beginning 1/1/2026

AJCC TNM STAGING

The TNM (Tumor, Nodes, Metastasis) staging items are required for State reporting only if available. Refer to the *STORE* manual and the *AJCC Cancer Staging Manual*, Eighth Edition for the codes and rules of classification for cases diagnosed 01/01/2018 and later.

ACoS Requirements
Hospitals with cancer programs approved by the American College of Surgeons (ACoS) must record pathological, or post therapy and/or clinical classifications of TNM and stage group in order to meet ACoS approval standards.

In October 1981, the Commission on Cancer resolved that the staging system of the American Joint Committee on Cancer (AJCC) would be used in all approved cancer programs. The AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcome, design follow-up strategies, and assess early detection results.

In 1982, breast cancer was the first site implemented. Effective January 1991, ACoS required AJCC TNM staging for all required (analytic) cases that had a staging scheme in the *AJCC Manual for Staging of Cancer*, Third Edition. The Commission has since published the fourth, fifth, sixth, seventh, and eighth editions of the manual. The effective dates for the various editions are listed below.

AJCC **Second Edition:**	Effective for cases diagnosed in 1988 or earlier.
AJCC **Third Edition:**	Effective for cases diagnosed from 1989 through 1992.
AJCC **Fourth Edition:**	Effective for cases diagnosed from 1993 through 1997.
AJCC **Fifth Edition:**	Effective for cases diagnosed from 1998 through 2002.
AJCC **Sixth Edition:**	Effective for cases diagnosed in 2003 through 2009.
AJCC **Seventh Edition:**	Effective for cases diagnosed 2010 and later.
AJCC **Eighth Edition:**	Effective for cases diagnosed 2018 and later.
AJCC **Nineth Edition:**	Effective for Cervix Uteri cases diagnosed 2021 and later.
AJCC **Nineth Edition:**	Effective for Appendix, Anus, Brain & Spinal Cord cases diagnosed 2023 and later.

AJCC Staging System
The TNM system for describing the extent of disease is based on the assessment of three anatomic factors (sometimes supplemented by nonanatomic factors):

T = The extent of the primary **tumor**
N = The absence or presence and extent of regional lymph **node** metastasis
M = The absence or presence of distant **metastasis**

For each of the anatomic factors there is a set of categories (most often defined by a number) that is specific for the disease site in the *AJCC Cancer Staging Manual.*

Definitions
a. Clinical (pretreatment) stage is based on information and evidence obtained before treatment. Symptoms, physical examination, imaging, endoscopy, biopsy, surgical exploration (without resection), and other relevant findings are the basis of clinical staging. Clinical stage of disease is assigned using all information available before initiation of definitive treatment, decision for watchful waiting, or within four months after the date of diagnosis, whichever is shortest, as long as the cancer has not progressed during that time frame. The clinical stage is essential to select and evaluate therapy.

b. Post therapy clinical stage is determined when the tumor has been microscopically sampled after neoadjuvant therapy or primary system/radiation therapy.

c. Pathological stage is based on clinical stage information supplemented/modified by operative findings and pathological evaluation of the resected specimens. This classification is applicable when surgery is performed before initiation of adjuvant radiation or systemic therapy.

d. Post therapy pathological stage is determined after treatment for patients receiving systemic and/or radiation therapy alone or as a component of their initial treatment, or as neoadjuvant therapy before planned surgery.

TEXT FIELDS FOR WORKUP

TEXT-DX PROC X-RAY/SCAN	Data Type: Text
TEXT-DX PROC LAB TEXTS	Data Type: Text
TEXT-DX PROC PE	Data Type: Text
TEXT-DX PROC OP	Data Type: Text
TEXT- DX PROC SCOPE	Data Type: Text
TEXT- DX PROC PATH	Data Type: Text
	ACoS: N/A State Registry: Required

Description
The fields listed above are optional text fields in the WebPlus abstract screen for recording information from the work-up for the tumor being reported. Facilities using other types of registry software should follow their vendor's instructions for recording text about the work-up. Although the items are optional, abstractors are strongly encouraged to document work-up that provides information about the malignancy or extent of disease that has not been recorded in other text fields.

Instructions
Text-Dx Proc X-rays/Scans
a. Record documentation from all X-ray, scans, and/or other imaging examinations that provide information about the malignancy or extent of disease.
b. Include, as applicable: Dates, primary site, histology, tumor location, tumor size, lymph nodes, positive and negative findings, and distant disease or metastasis.

Example: 01/01/2025 ABC Hospital, MRI Pelvis, Impression, 1.5cm lesion at right iliac crest suspicious for malignancy. No other suspicious lesions.

Text-Dx Proc Lab Tests
a. Record documentation from laboratory examinations other than cytology or histopathology. Tests can include tumor markers, serum and urine electrophoresis, special studies, etc.
b. Include, as applicable: Type of laboratory test/specimen(s), date(s) of test(s), and positive and negative findings.

Example: 01/01/2025 PSA (5.4) elevated

Text-Dx Proc PE
a. Record documentation from the history and physical examination about the history and clinical description of the current tumor.
b. Include, as applicable: Date of physical exam; age, sex, race/ethnicity; history that relates to cancer diagnosis; primary site; histology (if diagnosed prior to this admission); tumor location; tumor size; palpable lymph nodes; positive and negative clinical findings; impression pertaining to cancer diagnosis; and treatment plan.

Example: 52 Yr Old Married W/M with CO epigastric pain x 2 weeks. EGD with biopsy at ABC Endoscopy Center revealed a 2cm mass at the distal esophagus consistent with adenocarcinoma. Pt has a hx of prostate ca (2021, RALP).

Text- Dx Proc-Op
a. Record documentation of all surgical diagnostic and staging procedures.
b. Include, as applicable: 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.

Example: 01/01/2025 ABC Hospital, Dr Jon Doe, Rt Hemicolectomy with RLN Dissection. Findings: large 4.5cm mass at the splenic flexure. Tumor grossly invaded the bowel wall and involves the pericolonic tissue. Multiple pericolonic lymph nodes removed, appeared to be pathologically involved.

Text-DX Proc Scopes

a. Record documentation from endoscopic examinations that provide information for staging and treatment.
b. Include, as applicable: Date(s) of endoscopic exam(s); primary site; histology; tumor location; tumor size; lymph nodes; and positive and negative clinical findings.

Example: 01/01/2025 ABC Endoscopy Center, Colonoscopy, 5cm mass identified at the sigmoid colon, 18cm from anal verge, mass was fungated, bleeding, partially circumferential.

Text-DX Proc Path

a. Record documentation from pathology and cytology specimens.
b. Include, as applicable: Date(s) of pathology/cytology procedure(s); anatomic source of specimen, type of tissue specimen, tumor type, grade, gross tumor size, extent of tumor, involvement of resection margins, number of lymph nodes involved and examined, positive and negative findings (record positive results first), pathology consult review (outside pathology), additional comments by pathologist, including differential diagnosis considered and ruled our or favored histology/primary sites.

Example: 01/01/2025 Biopsy of RUL Lung nodule, Final Diagnosis: Poorly Differentiated Non-small cell carcinoma, IHC test will be performed. Addendum 1/15/2025: Adenocarcinoma.

GENERAL DEFINITIONS AND RULES FOR CODING TREATMENT

a. **Definitive (cancer-directed) treatment** is any therapy whose purpose is to *modify, control, remove, or destroy proliferating cancer tissue.* Treatment may be directed toward either the primary or metastatic sites, regardless of the patient's response.

Record all cancer-directed treatment administered to the patient in the first course of treatment. Include treatment provided in other facilities, palliative treatment, and failed treatments (the patient did not respond).

For statistical analysis of treatment, only the following codes are considered definitive treatment codes:

A100-A900, B100-B900 Surgery (removal of tumor cells)
20-98 Regional radiation treatment modality (destruction of cancer cells through rays, radons)
01-03 Chemotherapy (destruction of cancer cells through chemicals, drugs)
01 Hormone/steroid (endocrine) therapy (changing hormonal balance through hormones, steroids, or endocrine surgery)
01 Immunotherapy or Biological Response Modifier therapy (agents that alter the immune system or change the host response)
10-40 Hematologic transplant and endocrine procedures
1-3 Other cancer-directed therapy (nonspecific or experimental)

Codes that indicate a specific definitive treatment is not recommended, recommended but not given, or unknown whether recommended or given may be recorded in the treatment fields listed below.

(1) Chemotherapy codes 82-99
(2) Hormone Therapy codes 82-99
(3) Immunotherapy (Biological Response Modifier) codes 82-99
(4) Other Therapy codes 7, 8, and 9
(5) Hematologic Transplant and Endocrine Procedure codes 82-99

b. **Non-definitive (non cancer-directed) treatments** are performed to establish a diagnosis or stage, relieve symptoms, prolong the patient's life, or prepare the patient for cancer-directed therapy. Such treatments are not considered cancer-directed treatment. There is no expectation of reducing the size of the tumor or of delaying the spread of the disease. In effect, it is treatment of the patient, not the cancer.

The following examples of non-definitive treatment are <u>not</u> considered cancer-directed therapy, but can be recorded in the designated fields, when applicable.

(1) Surgical Diagnostic and Staging Procedure codes 01 – 09. These procedures include:
- Incisional biopsies
- Exploratory procedures with or without biopsies
- -otomy, -ostomy, or bypass only

(2) Palliative care, such as pain management, that does <u>not</u> include surgery, radiation or systemic treatment. (Such care can be recorded in NAACCR data item #3270, using codes 1-9. However, NAACCR data item #3270 is not collected by the State Cancer Registry - refer to the *STORE*.)

The following treatments are also considered non-definitive therapies and are not coded:

(1) Pain medication
(2) Oxygen
(3) Antibiotics administered for an associated infection
(4) Transfusions (e.g., to counteract blood dyscrasia resulting from chemotherapy)
(5) Medication (e.g., Epogen, Neupogen, or Procrit) to counteract blood dyscrasia resulting from chemotherapy
(6) Intravenous therapy to maintain fluid or nutritional balance
(7) Laser therapy directed at relieving symptoms
(8) Closure of colostomy in a patient with prior resection for cancer of the bowel

(9) Megestrol acetate, hormone therapy designed to improve nutritional status

c. **First Course of Treatment**
All cancer-directed therapies specified in the physician(s) treatment plan during or after the initial diagnosis are part of the first course of treatment. Documentation of a treatment plan may be found in several different sources, for example: medical clinic record, consultation reports, and outpatient records. The discharge plan may document all or part of the treatment plan.

(1) For all malignancies except leukemias, first course of treatment includes all methods of therapy recorded in the treatment plan and administered to the patient during or after the first diagnosis of cancer. Planned treatment may include multiple modes of therapy and may encompass intervals of a year or more.

If the therapy is a part of an established protocol or administered within accepted management guidelines for the disease, it is first course of treatment. When a treatment plan is not available or is unclear, consult the physician advisor.

If there is no treatment plan, established protocol, or management guidelines, and consultation with a physician advisor is not possible, use the principle: "Initial treatment must begin within four months of the date of initial diagnosis."

(2) For leukemias, first course of treatment includes all methods of therapy recorded in the treatment plan and administered to the patient during or after the first diagnosis of leukemia. Record all remission-inducing or remission-maintaining cancer-directed therapy as first course of treatment. Treatment regimens may include multiple modes of therapy and may encompass intervals of a year or more. Certain pediatric leukemia protocols span two years or more from induction to the end of maintenance. In these protocols, induction, consolidation, and maintenance are all first course of treatment.

If the therapy for leukemia is a part of an established protocol or administered within accepted management guidelines for the disease, it is first course of treatment. When a treatment plan is not available or is unclear, consult the physician advisor.

A patient may relapse after achieving a first remission. All therapy administered after the relapse is secondary or subsequent treatment.

d. **No Treatment**
No therapy is a treatment option (the patient refused therapy, the family/guardian refused therapy, the patient expired before therapy started, or the physician recommended no therapy). Therefore, first course of treatment may be no treatment. Record the date the decision was made not to treat in *Date of First Course of Treatment*.

e. **Treatment for Recurrence or Progression** (subsequent treatment) includes all treatments administered after the first course of therapy is complete or was stopped. A physician may stop treatment if the disease progresses despite therapy or if the patient fails to respond. The patient may also choose to stop treatment. If therapy is not part of the planned first course of treatment, it is considered subsequent therapy.

If there is a change in the original planned or administered treatment because the patient does not respond or the disease progresses, such therapy should be excluded from the first course of therapy and be considered as part of a second or subsequent course of therapy.

The State Cancer Registry does not require facilities to report subsequent therapy. The WEBPLUS program includes "Subsequent Treatment" screens for facilities that choose to report it.

f. **Treatment Dates**

(1) If your software allows collection of information for only one cancer-directed surgery, record the first date on which the patient has cancer-directed surgery. Record the surgery code with the highest priority according to the rules defined in the Appendix G for site-specific surgery codes.

(2) If the exact date that therapy was started is not known, the best estimate based on available information is acceptable. In the absence of an exact date of treatment, the date of hospital admission for the first cancer-directed therapy is acceptable. Recording an approximate date is preferable to leaving the date blank.

(3) If there is no basis for estimating, leave the month and day spaces blank. Every attempt should be made to enter the month and year, even if an estimate is necessary. In those rare instances when it is necessary to enter unknown month, day, or year, leave the appropriate spaces blank.

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

DESCRIPTIVE TERM USED	DATE CODE
Spring	April
The middle of the year	July
Fall	October
Winter	Try to determine if this means the beginning of the year (January) or the end of the year (December). Code as indicated.

(4) If cancer-directed therapy was initiated at another facility and you cannot approximate the date it began, leave the date blank. If you do know the exact date, you should record it, even if the therapy did not take place at your facility.

(5) If the documented, planned first course of therapy occurred after four months, enter the date this planned first course of therapy was initiated, even if it was initiated after four months from the date of initial diagnosis.

(6) If class of case is 38 (diagnosed at autopsy), do not record any treatment or treatment dates. *Date of First Course Treatment* would be left blank.

SURGICAL DIAGNOSTIC AND STAGING PROCEDURE

Item Length: 2
Data Type: Numeric
ACoS: Required
State Registry: Required

NAACCR Item #1350

Description
Identifies surgical procedure(s) performed in the work-up to diagnose and/or stage disease. The item is used to track the use of surgical procedure resources that are not considered treatment.

Codes
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. No exploratory procedure was done.

02 A biopsy (incisional, needle, or aspiration) was done to the primary site; or biopsy or removal of a lymph node to diagnose or stage lymphoma.

03 A surgical exploration only. The patient was not biopsied or treated.

04 A surgical procedure with a bypass was performed, but no biopsy was done.

05 An exploratory procedure was performed, and a biopsy of either the primary site or another site was done.

06 A bypass procedure was performed, and a biopsy of either the primary site or another site was done.

07 A procedure was done, but the type of procedure is unknown.

09 No information of whether a diagnostic or staging procedure was performed.

Instructions
a. Record the type of procedure performed as part of the initial diagnosis and work-up, whether this is done at your facility or another facility.

b. Only record positive procedures. For benign and borderline reportable tumors, report the biopsies positive for those conditions. For malignant tumors, report procedures if they were positive for malignancy.

c. If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, record code 02 (Incisional biopsy of primary site).

d. Record code 02 for lymphoma primaries when a lymph node is biopsied or removed for diagnosis or staging and that node is not the only node involved with lymphoma. When the lymph node removed is the only node involved with lymphoma, record the applicable surgical procedure code in *Surgical Procedure of Primary Site.*

e. Do not code surgical procedures that aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose and/or stage disease in this data item. Use the data item *Scope of Regional Lymph Node Surgery* to code these procedures. Do not record the date of surgical procedures that aspirate, biopsy, or remove regional lymph nodes in the data item *Date of Surgical Diagnostic and Staging Procedure*. See instructions for *Scope of Regional Lymph Node Surgery.*

f. Do not code brushing, washings, cell aspiration, or hematologic findings (peripheral blood smears). These are not considered surgical procedures and should not be coded in this item. *Aspirations can be a biopsy (tissue) or cytology (cells). Code tissue biopsy to Surgical Diagnostic and Staging Procedures. Code cytology cell aspiration in Diagnostic Confirmation.

g. Do not code excisional biopsies with clear or microscopic margins in this data item. Use the data item *Surgical Procedure of Primary Site* to code these procedures.

h. When a needle biopsy of the primary site is followed by an excisional biopsy or more extensive surgery and no tumor remains, do not consider the needle biopsy to be an excisional biopsy. Code the needle biopsy in the *Surgical Diagnostic and Staging Procedure* data item. Code the excisional biopsy or more extensive surgery in the *Surgical Procedure of Primary Site* data item.

i. Do not code non cancer-directed surgical procedures in this data item. Use the *Palliative Care* NAACCR item #3270 to code these procedures. The State Registry does not collect *Palliative Care* item #3270. Refer to the *STORE* manual for codes.

Codes with Examples:

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.

02 During a colonoscopy, a biopsy of a primary rectal mass 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. There was no attempt to treat. A bypass was performed to alleviate symptoms.

05 An open, exploratory procedure was performed for primary colon carcinoma with biopsy of suspicious liver lesions.

06 Esophagogastrostomy 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.

DATE OF FIRST COURSE OF TREATMENT

Item Length: 8
Data Type: Numeric
ACoS: Required
State Registry: Required

NAACCR Item #1270

Description
This is a required 8-character field for recording the date on which treatment (surgery, radiation, systemic, or other therapy) of the patient began at any facility. Determine whether your software vendor uses the traditional format for date entry (MMDDCCYY) or the interoperable format (CCYYMMDD). The WEBPLUS program uses the traditional format.

Codes

	Month	Day	Year
01	January	01	Use four-digit year (e.g., 2021)
02	February	02	blank = Year unknown
03	March	03	
04	April	...	
05	May	...	
06	June	25	
07	July	26	
08	August	...	
09	September	30	
10	October	31	
11	November	blank = Day unknown	
12	December		
blank	Month unknown		

Instructions

a. Record the earliest of the following dates: *Date of First Surgical Procedure, Date Radiation Started, Date Chemotherapy Started, Date Hormone Therapy Started, Date Immunotherapy Started, Date of Hematologic Transplant and Endocrine Procedure,* or *Date Other Treatment Started.* Record the earliest treatment date, whether it occurs at your facility or elsewhere. For example, if the patient receives preoperative radiation elsewhere before admission to your facility for surgery, record the date of the preoperative radiation.

b. If active surveillance or watchful waiting is selected as the first course of treatment, record the date this decision is made.

c. In cases of non-treatment, in which a physician decides not to treat a patient or a patient's family or guardian declines all treatment, record the date this decision was made.

d. If the cancer was diagnosed at autopsy and not suspected prior to that, leave this item blank.

e. Do not record the date of incisional, core, or fine needle biopsy in this field, even if it is the only procedure performed.

f. Record the date of an excisional biopsy as the *Date of First Course of Treatment*, whether followed by further definitive therapy or not. The excisional biopsy date will remain *Date of First Course of Treatment* even when followed by other surgery of the primary site. Enter the date of the excisional biopsy, whether or not residual tumor was found at the time of later resection. If the biopsy was not stated to be excisional, but no residual tumor was found at a later resection, assume that the biopsy was excisional. Use the date of admission if an exact treatment date is not obtainable for the excisional biopsy.

Example: A breast cancer patient has an excisional biopsy on June 26, 2021. The patient has a modified radical mastectomy July 5, 2021. Record June 26, 2021 in the *Date of First Course of Treatment* field.

g. If the exact date of the beginning of treatment is not available, record an approximate date. If information is limited to a description, use the following:

DESCRIPTIVE TERM USED	DATE CODE
Spring	April
The middle of the year	July
Fall	October
Winter	Try to determine if this means the beginning of the year (January) or the end of the year (December). Code as indicated.

j. If the date of first course of treatment cannot be determined at all or is not applicable, leave the date of first course of treatment blank and record the reason in *Date of First Course of Treatment Flag*. See the *Date of First Course of Treatment Flag* section for examples illustrating the relationships among these items. **(No longer applicable for 1/1/2023+)**

k. If the first course of treatment plan changes due to an improvement in the tumor burden, the added treatment would still be considered first course. An example is palliative chemotherapy/radiation is recommended and administered per the first course treatment plan. Initially resection of primary tumor was contraindicated due to tumor size and location. Follow up imaging shows an improvement in tumor burden and treatment plan changed since tumor is now resectable to include surgery. Even though the primary tumor resection was not noted in the FCOT plan, the resection would be captured as first course of treatment since there was no progression of tumor.

DATE OF FIRST COURSE TREATMENT FLAG

Item Length: 2
Data Type: Numeric
ACoS: Required
State Registry: Required

NAACCR Item #1271

*Required if applicable for cases diagnosed 01/01/2015-12/31/2022

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of First Course Treatment* (NAACCR Item #1270). This data item was added to Volume II Version 12 (effective January 2010).

Rationale
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes
10 No information whatsoever can be inferred from this exceptional value (It is unknown whether treatment was administered.)
11 A valid date is not applicable in this context (for example, autopsy only case)
12 A valid date is applicable but not known (for example, treatment was administered but the date is unknown)
Blank A valid date is coded in the *Date of First Course Treatment* item (NAACCR Item #1270).

Instructions
a. Leave this item blank if *Date of First Course Treatment* has a full or partial date recorded.
b. Use code 12:
If the *Date of First Course Treatment* cannot be determined at all, but the patient did receive first course treatment, or;
If a decision not to treat was made, but the date is totally unknown, or;
If a decision to use active surveillance was made, but the date is totally unknown.
c. Use code 10 if it is unknown whether any treatment was administered.
d. Use code 11 if the initial diagnosis was made at autopsy.
e. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

Examples:

Description	Date (Leave unknown portions blank.)	Date of 1st Crs Rx Flag
Full date known	*01/08/2021 or 2021/01/08	Blank
Month & year known	*01/_ _/2021 or 2021/01/_ _	Blank
Year only known	*_ _/_ _/2021 or 2021/_ _/_ _	Blank
Unknown if Rx given	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	10
Diagnosed at autopsy	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	11
Rx given, unknown date	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	12

* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The WEBPLUS program uses the traditional format. The computer will store either in the interoperable format.

DATE MOST DEFINITIVE SURGICAL RESECTION OF PRIMARY SITE

Item Length: 8
Data Type: Numeric
ACoS: Required
State Registry: *Required

NAACCR Item #3170

*Required for cases diagnosed 01/01/2015 and later.

Description
This is a required 8-character field for recording the date the most definitive surgical procedure of the primary site was performed. Determine whether your software vendor uses the traditional format for date entry (MMDDCCYY) or the interoperable format (CCYYMMDD). The WEBPLUS program uses the traditional format.

Codes

	Month	Day	Year
01	January	01	Use four-digit year (e.g., 2021)
02	February	02	blank = Year unknown
03	March	03	
04	April	...	
05	May	...	
06	June	25	
07	July	26	
08	August	...	
09	September	30	
10	October	31	
11	November	blank = Day unknown	
12	December		
blank	Month unknown		

Instructions

a. Record the date on which the surgery described by *Surgical Procedure of Primary Site* (NAACCR Item #1290) was performed at your facility or elsewhere. For example, if the patient receives surgery elsewhere before admission to your facility for adjuvant treatment, record the date of the surgery.

b. If the exact date of surgery is not available, record an approximate date. If information is limited to a description, use the following:

DESCRIPTIVE TERM USED	DATE CODE
Spring	April
The middle of the year	July
Fall	October
Winter	Try to determine if this means the beginning of the year (January) or the end of the year (December). Code as indicated.

c. If the date of surgery cannot be determined at all or is not applicable, leave the date of most definitive surgery blank and record the reason in *Date of Most Definitive Surgery Flag*. See the *Date of Most Definitive Surgery Flag* section for examples illustrating the relationships among these items. **(No longer applicable for 1/1/2023+)**

DATE OF MOST DEFINITIVE SURGERY FLAG

Item Length: 2
Data Type: Numeric
ACoS: Required
State Registry: *Required

NAACCR Item #3171

*Required if applicable for cases diagnosed 01/01/2015-12/31/2022.

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of Most Definitive Surgical Resection of Primary Site* (NAACCR Item #3170). This data item was added to Volume II Version 12 (effective January 2010).

Rationale
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes
10 No information whatsoever can be inferred from this exceptional value (It is unknown whether treatment was administered.)
11 A valid date is not applicable in this context (for example, no surgery performed)
12 A valid date is applicable but not known (for example, surgery was performed but the date is unknown)
Blank A valid date is coded in the *Date of Most Definitive Surgical Resection of Primary Site* item (NAACCR Item #3170).

Instructions
a. Leave this item blank if *Date of Most Definitive Surgical Resection of Primary Site* has a full or partial date recorded.
b. Use code 12 if the *Date of Most Definitive Surgical Resection of Primary Site* cannot be determined, but the patient did receive first course surgery.
c. Use code 10 if it is unknown whether any surgery was performed.
d. Use code 11 if no surgical procedure was performed.
e. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

Examples:

Description	Date (Leave unknown portions blank.)	Date of 1st Crs Rx Flag
Full date known	*01/08/2021 or 2021/01/08	Blank
Month & year known	*01/_ _/2021 or 2021/01/_ _	Blank
Year only known	*_ _/_ _/2021 or 2021/_ _/_ _	Blank
Unknown if surgery performed	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	10
No surgery performed	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	11
Surgery performed, unknown date	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	12

* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The WEBPLUS program uses the traditional format. The computer will store either in the interoperable format.

TREATMENT STATUS

Item Length: 2
Data Type: Numeric
ACoS: Required
State Registry: *Required

NAACCR Item #1285

*Required if available for cases diagnosed 01/01/2010and later.

Description
This data item summarizes whether the patient received any first course 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* to document whether treatment was or was not given, it is unknown if treatment was given, or treatment was given on an unknown date.

Codes
0 No treatment given
1 Treatment given
2 Active surveillance (watchful waiting)
9 Unknown if treatment was given

Instructions for Coding
a. Leave this item blank for cases diagnosed prior to 2010,
b. Treatment given after a period of active surveillance is considered subsequent treatment and should **not** be coded as "Treatment given" (code 1) in this item.
c. Use code 0 when the patient does not receive any treatment. Treatment may have been refused or not recommended. *Scope of Regional Lymph Node Surgery* may be coded 0, 1-7, or 9.
d. Use code 1 when the patient receives any of the following:
   - Surgery of primary site
   - Surgical procedure of other site
   - Radiation therapy
   - Chemotherapy
   - Hormone therapy
   - Immunotherapy
   - Hematologic transplant and endocrine procedures
   - Other therapy
e. Use code 2 when there is documentation that the patient is being monitored using active surveillance/watchful waiting/deferred therapy or other similar options.

Examples:

Code	Reason
0	An elderly patient with pancreatic cancer requested no treatment.
0	The patient is expected to receive radiation, but it has not occurred yet (Code 8 is recorded in *Reason for No Radiation*.)
2	The treatment plan for a patient with lymphoma is active surveillance.

SURGICAL PROCEDURE OF PRIMARY SITE (03-2022)
(CANCER-DIRECTED SURGERY)

NAACCR Item #1290

Item Length: 2
Data Type: Numeric
ACoS: Required
State Registry: Required

*Required if applicable for cases diagnosed 01/01/1997-12/31/2022

Description
This is a required 2-character field to record the surgical procedure performed to the primary site as part of first course of therapy. Record all procedures done at your facility and procedures done at other facilities, if known. Record all procedures performed as part of first course therapy, even if palliative.

Codes
The site-specific surgery codes are provided in Appendix G of this manual. Definitions and rules for the surgery codes are provided at the beginning of Appendix G.

General Code Structure (See Appendix G for site-specific codes.)

Code(s)	Description
00	None; no surgical procedure of primary site; diagnosed at autopsy only
10-19	Site-specific codes. Tumor destruction; no pathologic specimen or unknown whether there is pathologic specimen
20-80	Site-specific codes. Resection; pathologic specimen
90	Surgery, NOS. A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.
98	Special code for the following sites/schema: C420, C421, C423, C424, C760-C768, C809 except death certificate only. (See site-specific codes for the sites and histologies).
99	Unknown if surgery performed; death certificate only

Definitions

a. Definitive (cancer-directed) surgery is surgery that **removes or destroys proliferating cancer tissue**. This includes excisional biopsy with microscopic residual disease or no residual disease. Valid codes for cancer-directed surgery of the primary site are 10-90.

b. Non cancer-directed procedures are performed to diagnose or stage the disease (*Surgical Diagnostic and Staging Procedure* codes 01-07), or for relief of symptoms (*Palliative Care* NAACCR item #3270 code 1). Record *Surgical Diagnostic and Staging Procedures* in the designated field of the WEBPLUS "First Course of Treatment" screens. The State Registry does not collect the *Palliative Care* item #3270.

   The following procedures are examples of exploratory (diagnostic or staging) surgery (code 03 without biopsy or code 05 with biopsy).

   - Celiotomy
   - Laparotomy
   - Cystotomy
   - Nephrotomy
   - Gastrotomy
   - Thoracotomy, including Chamberlain procedure

   The following non cancer-directed procedures are examples of bypass surgery (code 04 without biopsy or code 06 with biopsy). Code only if performed as part of the initial diagnosis and work-up. If performed for palliation only, code in *Palliative Care* NAACCR item #3270 if collected. The State Registry does not collect the *Palliative Care* item #3270.

   - Colostomy
   - Nephrostomy
   - Esophagostomy
   - Tracheostomy
   - Gastrostomy
   - Urethrostomy

The following examples of diagnostic (non cancer-directed) procedures are not considered exploratory surgery. These procedures do not require an incision, since entry into a body cavity is made through a natural orifice. Code only if a biopsy was done as part of the procedure.

- Bronchoscopy
- Colonoscopy
- Cystoscopy
- Endoscopy
- ERCP (endoscopic retrograde cholangiopancreatography)
- Laryngoscopy
- Mediastinoscopy
- Dilatation & curettage (D & C) – Use non cancer-directed surgery code 02 when primary site is corpus uteri. Use the cancer-directed surgery code only when performed for in situ cancer of the cervix.

Brushings, washings, aspiration of cells, and hematologic findings (peripheral blood smears) are not surgical procedures.

Instructions

a. After determining that cancer-directed surgery of the primary site was performed, use the best information in the operative and pathology reports to determine the operative procedure. The operative report title may not have adequate information for the surgery code. Use the operative report text and the pathology report to correctly identify the procedure performed. Use the information from the pathology report when an operative report is unclear or is inconsistent.

Exception: If the pathology report states they cannot give an accurate accounting of organs removed (tumor encasement, crush artifact, etc).

b. In the "Surgery" field, record the site-specific 2-digit surgical code from Appendix G for the specific surgery performed as part of the first course of treatment.
For WEBPLUS users, record the date the surgery was performed in the adjacent "Date" field.

c. Record Surgical Diagnostic and Staging Procedures in the designated field of the WEBPLUS "First Course of Treatment" screens. Do record all biopsies as well as cancer-directed surgical procedures.

d. More than one cancer-directed surgical procedure can be recorded in the WEBPLUS "First Course of Treatment" screens.

If a biopsy (excluding needle biopsy or any biopsy where the margins are not described in the path report) was followed by a re-excision or wide excision within the first course of cancer-directed therapy and the path report for the re-excision or wide excision is negative for residual tumor, code the biopsy as an excisional biopsy. In the WEBPLUS program or the paper abstract, record both procedures, each with its respective date. Record the excisional biopsy date as the date of first course of treatment. *ISCR will no longer accept paper abstracts beginning 1/1/2026

Example 1: A patient has an excisional breast biopsy at your hospital January 12, 2021. The pathology report reveals an axillary node with micrometastasis. The patient opted to have a mastectomy on March 21, 2021. Code the procedures as follows:

Surgery Code	Procedure	Date
41	Simple mastectomy	03/21/2021
22	Excisional biopsy	01/12/2021

If you can record only one surgical procedure in your system, record the surgical code with the highest priority according to the rules on the following page and use the first date on which the patient has cancer-directed surgery (41-01/12/2021).

Example 2: A patient had a breast biopsy on March 15, 2021 in the physician's office. A simple mastectomy was done at your hospital on March 27, 2021. Both procedures should be recorded, as follows:

Surgery Code	Procedure	Date
41	Mastectomy	03/27/2021
02	Incisional biopsy of primary site	03/15/2021

If you can record only one surgical procedure in your system, code surgery 41 with 03/27/2021 as the date of treatment.

e. If the patient had no surgery at your hospital, but had surgery at another facility, you may enter the surgery information from the other hospital, if known. In one of the WEBPLUS "First Course Treatment" screen(s), record the facility ID and the appropriate surgery code and date. In the paper abstract, identify the facility in the *Description of Treatment* text field. *ISCR will no longer accept paper abstracts beginning 1/1/2026

f. If the patient did not have cancer-directed surgery, record the reason as instructed in the *Reason for No Surgery of Primary Site* section.

Special Rules

a. Coding Multiple Definitive Surgeries

(1) If a single field is available for the data item *Surgical Procedure of Primary Site* or if a summary treatment field is provided and the patient has multiple cancer-directed surgeries of the primary site, code the most invasive, definitive surgery. For codes 00 through 79, the code **positions** are hierarchical. Last-listed codes take precedence over codes listed above. Use codes 80 and 90 only if more precise information about the surgery is unavailable.

Example: A patient has a colonoscopy with removal of a polyp in the sigmoid colon (code 28). The pathology report identifies carcinoma extending into the stalk. A week later, the patient has a hemicolectomy (code 40). Code the hemicolectomy since it is the most invasive, definitive surgery.

(2) If multiple fields are available to record consecutive surgical events, code each consecutive surgery of the primary site. For the example above, record both procedures, each with its respective date. Record the polypectomy date as the date of first course of treatment.

b. Coding Surgery for Multiple Primaries

Code the appropriate surgery for each site when multiple primaries are excised at the same time.

Example 1: A patient who has cancer of the cervix and of the endometrium enters your facility for a total abdominal hysterectomy. Code a total abdominal hysterectomy for each of the two primaries.

Example 2: A patient has colon and skin cancer. The patient had a hemicolectomy and a wide excision of the skin lesion. Code the colectomy for colon and the wide excision for skin.

c. If a surgical procedure removes the remaining portion of an organ that had been partially resected previously for any condition, code as total removal of the organ. If none of the primary organ remains, the code should indicate that this is the case.

Example 1: Resection of a stomach that had been partially excised previously is coded as total removal of stomach.

Example 2: Removal of a cervical stump is coded as total removal of uterus.

Example 3: Lobectomy of a lung with a previous wedge resection is coded as total removal of lobe.

d. Code 98 applies to specific tumors that cannot be clearly defined in terms of primary or non-primary site. Use code 98 for the following sites/schema: C420, C421, C423, C424, C760-C768, C809. *Reason for No Surgery of Primary Site* must be coded to 1.

Exception: For death certificate only cases, use code 99.

e. For extra-lymphatic lymphoma, code surgery using the site-specific surgery coding scheme for the primary site (not the lymph node scheme).

f. For WEBPLUS users: Record the date for Scope of Regional Lymph Node Surgery (excluding code 1) or Surgical Procedure/Other Site in one of the treatment screens.

g. For facilities that collect *Palliative Care* NAACCR item #3270*:* 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 *Palliative Care* field. The State Registry does not collect the *Palliative Care* item #3270.

SURGICAL PROCEDURE OF PRIMARY SITE
(NAACCR: RX Summ—Surg Prim Site 2023)

NAACCR Item #1291

Item Length: 4
Data Type: Alphanumeric
ACoS: Required
State Registry: Required Site Specific

*Required for cases diagnosed 1/1/2023 and later

Description
Describes a surgical procedure that removes and/or destroys tissue of the primary site that is performed as part of the initial diagnostic and staging work-up or first course of therapy.

Codes
The site-specific surgery codes are provided in Appendix G of this manual. Definitions and rules for the surgery codes are provided at the beginning of Appendix G.

General Code Structure (See Appendix G for site-specific codes.)

Code(s)	Description
A00	None; no surgical procedure of primary site; diagnosed at autopsy only
A100-A190	Site-specific codes. Tumor destruction: no pathologic specimen or unknown whether there is pathologic specimen
A200-A800	Site-specific codes. Resection; pathologic specimen
A900	Surgery, NOS. A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.
A980	Special code for the following sites/schema: C420, C421, C423, C424, C760-C768, C809 except death certificate only. (See site-specific codes for the sites and histologies).
A990	Unknown if surgery performed, death certificate only

All 2023 site specific surgery codes begin with a letter A except for skin which start with a letter B to indicate a significant change in coding

Use the entire **operative report** as the primary source document to determine the best surgery of primary site code. The body of the operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report take precedence.

Coding Instructions

1. Code A000 or B000 when
   - No surgery was performed on the primary site, OR
   - First course of treatment was active surveillance/watchful waiting, OR
   - Case was diagnosed at autopsy

   Note: Codes A000 and B000 exclude all sites and histologies that would be coded as A980.
2. Use the site-specific coding scheme corresponding to the primary site or histology
3. Code the most invasive, extensive, or definitive surgery if the patient has multiple surgical procedures of the primary site even if there is no residual tumor found in the pathologic specimen from the more extensive surgery.
4. Code an excisional biopsy even when documented as incisional when
   - All disease is removed (margins free) OR
   - All gross disease is removed and there is only microscopic residual at the margin.
   - Note 1: Do not code an incisional biopsy as an excisional biopsy where there is macroscopic residual disease.
   - Note 2: Shave or punch biopsies are most often diagnostic. Code as a surgical procedure only when the entire tumor is removed and margins meet the criteria in either 4a. or 4b. **Example:** Shave biopsy performed for a suspicious lesion on the skin of the right arm that has been changing in size and color. The shave biopsy pathology report showed malignant melanoma with only microscopically positive margins. Code the shave biopsy as an excisional biopsy. (Use most appropriate code for type of excisional biopsy, shave vs. punch vs elliptical/fusiform)

5. Code total removal of the primary site when a previous procedure resected a portion of the site and the current surgery removed the rest of the organ. The previous procedure may have been cancer directed or non-cancer directed surgery.
   Example: Left thyroidectomy for suspicious nodules. Path showed papillary carcinoma. Completion thyroidectomy was performed. Code surgery of primary site as total thyroidectomy (A500)
6. Assign the code that reflects the **cumulative effect** of all surgeries to the primary site.
   - When a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, code the total or final results. Do not rely on registry software to perform this task.
     Example: Rt Breast-Partial mastectomy and SLN bx and Ax LN dissection (2011). Separate right breast primary 2020 treated with total mastectomy and removal of one involved axillary LN. The operative report only refers to this as a non-sentinel lymph node. Cumulatively, this patient has undergone an MRM since there were likely no remaining axillary LNs (from the 1st surgery in 2011). For the 2020 Rt breast primary, code the cumulative effect of the surgery done in 2011 plus the surgery done in 2020.
7. Code the removal of regional or distant tissue/organs when they are resected in continuity with the primary site (en bloc) and that regional organ/tissue is listed in the Surgery of Primary Site 2023 codes. Specimens from an en bloc resection may be submitted to pathology separately.
   - Code an en bloc removal when the patient has a hysterectomy with omentectomy
8. Code surgery for extra-lymphatic lymphoma using the site-specific surgery coding scheme for the primary site. Do not sue the lymph node scheme.
9. Assign the surgery codes(s) that best represents the extent of the surgical procedure that was actually carried out when surgery is aborted. If the procedure was aborted before anything took place, assign code A000.
10. Code A800, B800, A900 or B900 only when there is no specific information
11. Code A980 for the following primary sites unless the case is death certificate only
    - Any case coded to C420, C421, C423, C424, C760-C768, or C809
12. When *Surgery of Primary Site 2023* is coded to A980
    - Code *Surgical Margins of Primary Site* (#1320) to 9
    - Code *Reason for no Surgery of Primary Site* (#1340) to 1
13. Code A990 or B990 for death certificate only (DCO) cases ore if patient record does not state whether a surgical procedure of the primary site was performed (i.e., is unknown)
14. Leave blank for diagnosis years 2003-2022

DATE OF SURGERY FLAG

Item Length: 2
Data Type: Numeric
ACoS: Required
State Registry: Required

NAACCR Item #1201

*Required if applicable for cases diagnosed 01/01/2015-12/31/2022

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of First Surgical Procedure* (NAACCR Item #1200). This data item was added to Volume II Version 12 (effective January 2010).

Rationale
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes
10 No information whatsoever can be inferred from this exceptional value. (It is unknown if any surgical procedure was performed.)
11 No valid date is applicable in this context (for example, no surgical procedure was performed).
12 A valid date is applicable but not known. (Surgery was performed but the date is unknown.)
Blank A valid date is coded in item *Date of First Surgical Procedure* (NAACCR Item #1200).

Instructions
a. Leave this item blank if *Date of First Surgical Procedure* (NAACCR Item #1200) has a full or partial date recorded.
b. Use code 12 if the *Date of First Surgical Procedure* cannot be determined, but the patient did receive first course surgery.
c. Use code 10 if it is unknown whether any surgery was performed.
d. Use code 11 if the no surgical procedure was performed.
e. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

Examples:

Description	Date (Leave unknown portions blank.)	Date of Surgery Flag
Full date known	*01/08/2021 or 2021/01/08	Blank
Month & year known	*01/_ _/2021 or 2021/01/_ _	Blank
Year only known	*_ _/_ _/2021 or 2021/_ _/_ _	Blank
Unknown if surgery performed	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	10
No surgery performed	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	11
Surgery performed, date unknown	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	12

***** For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The WEBPLUS program uses the traditional format. The computer will store either in the interoperable format.

SCOPE OF REGIONAL LYMPH NODE SURGERY

NAACCR Item #1292

Item Length: 1
Data Type: Numeric
ACoS: Required
State Registry: Required

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

Codes
0 None
1 Biopsy or aspiration of regional lymph node(s)
2 Sentinel lymph node biopsy (only)
3 Number of regional nodes removed unknown or not stated; regional lymph nodes removed, NOS
4 1 to 3 regional lymph nodes removed
5 4 or more regional lymph nodes removed
6 Sentinel node biopsy and procedures that would be coded 3, 4, or 5 performed at the same time, or timing not stated
7 Sentinel node biopsy and procedures that would be coded 3, 4, or 5 performed at different times
9 Unknown or not applicable

Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), or a more extensive dissection of regional lymph nodes, or a combination of both SLNBx and regional lymph node dissection. Review both the surgeon's planned procedure as well as the description of the procedure that was actually performed. The operative report takes precedence over the pathology report for distinguishing between SLNBx and regional lymph node dissection or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node dissection.

Definitions

Code	Definition
0	No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.
1	Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement of disease. Notes: If additional procedures were performed on the lymph nodes, use the appropriate code 2-7. For breast, biopsy or aspiration of regional lymph node(s) is uncommon. Confirm that the procedure was not actually a sentinel lymph biopsy.
2	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, radio-label, or a combination at the site of the primary tumor. Notes: Additional non-sentinel nodes can be taken during the same operative procedure. The additional nodes may be discovered by the pathologist or selectively removed (harvested) as part of the SLNBx procedure by the surgeon. If the operative report confirms that a regional lymph node dissection followed the SLNBx, use code 6.
3	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	Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. Note: Code 4 should be used infrequently. Ensure that the procedure is not specified as SLNBx in the operative report.

Code	Definition
5	Sampling or dissection of four or more regional lymph nodes. Notes: If relatively few nodes were examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a relatively large number of nodes was examined pathologically, review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same, or separate, procedure (code 6 or 7).
6	SLNBx and procedures that would be coded 3, 4, or 5 performed at the same time, or timing not stated. Notes: Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. If relatively few nodes were examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a SLNBx is attempted and the patient fails to map (no sentinel lymph nodes are identified by the dye and/or radio-label injection) and the surgeon performs a more extensive dissection of regional lymph nodes, use code 6.
7	SNLBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events. Notes: Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. If relatively few nodes were examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2).
9	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.

Instructions

a. Record the scope of regional lymph node surgery for each surgical event even if no surgery of the primary site was performed.

b. Record surgical procedures that 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 data item *Date of First Course Treatment* and/or *Date of First Surgical Procedure* as appropriate.

c. Codes 0-7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.

d. If two or more surgical procedures of regional lymph nodes are performed, the code for each subsequent procedure must include the cumulative effect of all preceding procedures. For example, a sentinel lymph node biopsy followed by a regional lymph node dissection at a later time is coded 7.

e. Code the removal of regional nodes for both primaries when the patient two primaries with common regional lymph nodes.

f. Use code 9 for the following:
   - Any Schema ID with primary site: C42.0, C42.1, C42.3, C42.4, C70.0-C70.9, C71.0-C72.9, C75.1-C75.3, C76.1-C76.8, C77.0-C77.9, C80.9;
   - Lymphoma (excluding CLL/SLL, Schema ID 00790)
   - Lymphoma (CLL/SLL, Schema ID 00795)
   - Plasmacytoma, bone (9731/3).

g. 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*.

h. Refer to the current *AJCC Cancer Staging Manual* for site-specific identification of regional lymph nodes.

i. For facilities that collect *Palliative Care* NAACCR item #3270*:* 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 *Palliative Care* field. The State Registry does not collect the *Palliative Care* item #3270*.*

Codes with Examples:

0 No effort was made to locate sentinel lymph nodes and no nodes were found in pathologic analysis.
2 Primary site is breast (C50.1). There was an attempt at sentinel lymph node dissection, but no lymph nodes were found in the pathological specimen.
1 Primary site is pharynx (C14.0). Aspiration of regional lymph node was performed to confirm histology of widely metastatic disease.
2 Primary site is skin of back (C44.5). Histology is melanoma. A sentinel lymph node dissection was done with the removal of one lymph node. This node was negative for disease.
3 Primary site is prostate (C61.9). Bilateral pelvic lymph node dissection was performed.
6 Primary site is breast (C50.3). Sentinel lymph node biopsy of right axilla, followed by right axillary lymph node dissection during the same surgical event.
7 Primary site is breast (C50.4). Sentinel lymph node biopsy of left axilla, followed by a left axillary lymph node dissection in a second procedure 5 days later.
9 Primary site is lung (C34.9). Patient was admitted for radiation therapy following surgery for lung cancer. There is no documentation on the extent of surgery in the patient record.

Surgical Procedure/Other Site

NAACCR Item #1294

Item Length: 1
Data Type: Numeric
ACoS: Required
State Registry: Required

Description
This item records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site.

Codes
0 None
1 Nonprimary surgical procedure performed, unknown whether regional or distant
2 Nonprimary surgical procedure to other regional sites
3 Nonprimary surgical procedure to distant lymph node(s)
4 Nonprimary surgical procedure to distant site
5 Combination of codes
9 Unknown

Definitions

Code	Definition
0	No surgical procedure of nonprimary site was performed. Diagnosed at autopsy.
1	Nonprimary surgical resection other site(s), unknown if the site(s) is regional or distant.
2	Resection of regional site.
3	Resection of distant lymph node(s).
4	Resection of distant site.
5	Any combination of surgical procedures that would be coded 2, 3, or 4.
9	It is unknown whether any surgical procedure of a nonprimary site was performed. Death certificate only.

Instructions

a. Assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgery code.

b. Do not code incidental removal of tissue or organs as *Surgical Procedure/Other Site.*

c. Record the *Surgical Procedure/Other Site* for each surgical event even if no surgery of the primary site was performed.

d. Use code 1:
- When any surgery is performed to remove tumors for any case coded to primary site C42.0, C42.1, C42.3, C42.4, C76.0-C76.8, C77.0-C77.9, or C80.9, excluding cases coded to the Cervical Lymph Nodes and Unknown Primary (Schema ID 00060);
- When the involved contralateral breast is removed for a single breast cancer. See also notes and codes for breast surgery in Appendix G.

e. If multiple first course surgical procedures coded in this item are performed for a single primary, use the code that represents the cumulative effect of those surgeries.

f. For facilities that collect *Palliative Care* NAACCR item #3270*:* 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 *Palliative Care* field. The State Registry does not collect the *Palliative Care* item #3270.

Codes with Examples:

0 Primary site is colon (C18.1). 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 Primary site is colon (C18.3). Surgical ablation of solitary liver metastasis, hepatic flexure primary.
4 Primary site is rectosigmoid (C19.9). Excision of multiple liver metastasis.
4 Primary site is lung (C34.9). Removal of solitary brain metastasis.
5 Primary site is anus (C21.0). Excision of solitary liver metastasis and one large hilar lymph node.

REASON FOR NO SURGERY OF PRIMARY SITE

NAACCR Item #1340

Item Length: 1
Data Type: Numeric
ACoS: Required
State Registry: *Required

*Required if available for cases diagnosed 01/01/2006 and later.

Description
This is an optional 1-character field for recording the reason that no surgery was performed on the primary site. This item is related only to first course of therapy. This information is to be coded if it is available in the medical record.

Codes
0 Surgery of the primary site was performed.
1 Surgery of primary site was not performed because it was not part of the planned first course treatment. Diagnosed at autopsy.
2 Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (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 of therapy. No reason was noted in the 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. Death certificate only cases.

Instructions
a. If *Surgical Procedure of Primary Site* is coded 00, then record the reason based on documentation in the patient record.

b. Use code zero (0) if the record specifies that surgery of the primary site was performed. (*Surgery of Primary Site* is coded in the range of 10-90.)

c. Use code 1 if the treatment plan offered multiple alternative treatment 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.

d. Use code 1 if *Surgical Procedure of Primary Site* is coded 98 (for primary sites C420, C421, C423, C424, C760-768, C809).

e. Use 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.

f. Use 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.

g. Use code 9 if the treatment plan offered multiple choices, but it is unknown which treatment, if any, was provided.

Codes with Examples:
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.

PHASE I RADIATION TREATMENT MODALITY

Item Length: 2
Data Type: Numeric
ACoS: Required
State Registry: Required

NAACCR Item #1506

Description
This is a required 2-character field to record the radiation modality administered during the first phase of radiation treatment in the first course of treatment. The radiation modality code indicates whether the treatment was external beam, brachytherapy, a radioisotope, a subtype of those, or a combination of modalities. Record radiation delivered at your facility, as well as radiation done in any other facilities, if known.

This item, in conjunction with *Phase I Radiation External Beam Planning Technique*, replaces the historical *Regional Radiation Modality,* which converted to the two new radiation items upon upgrade to NAACCR v18 software. The items will then be required for all cases regardless of diagnosis year.

Note: In pre-2018 case abstracts, the historical *Regional Radiation Modality* must be coded along with the two new radiation items.

Codes and Descriptions

Codes	Description
00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, interstitial, LDR
11	Brachytherapy, interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-223
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
98	Radiation treatment administered; modality unknown
99	Unknown if radiation treatment administered.

Instructions
Select the code for the radiation treatment modality that the patient received as part of the first course of treatment. If necessary, obtain assistance from the radiation oncologist to determine the radiation treatment modality to ensure consistent coding. Record all radiation that is given as part of first course therapy, even if it is palliative.

a. Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment.
b. For purposes of this data item, photons, x-rays and gamma rays are equivalent.

c. Use code 13 (Radioisotopes, NOS) for radioembolization procedures, e.g., intravascular Yttrium-90 for cases diagnosed 01/01/2018 or later. For cases diagnosed prior to 1/1/2018 use code 07 Brachytherapy NOS.
d. If this data item is coded to any of the external beam codes (01-06 or 12), record the planning technique in the data item *Phase I External Beam Radiation Planning Technique*.
   If this data item is coded to any of the brachytherapy or radioisotopes codes (07-16), record code 88 in the data item *Phase I External Beam Radiation Planning Technique*.
e. Do not confuse a radioiodine *scan* with treatment. Only treatment is coded in this item.

In the Regional Radiation Treatment Modality field, enter the code from the list above for the radiation treatment modality that the patient received.

For WEBPLUS users, record the date the radiation treatment started in a hospital-specific treatment screen in the date field adjacent to the *Radiation* item.

Radiation Treatment Summary Codes (for cases diagnosed prior to 2018)
(For WEBPLUS users, record in the single digit SEER field in the treatment screen.)

0 No radiation therapy, diagnosed at autopsy (Radiation treatment modality code 00.)

1 Beam radiation (Radiation treatment modality codes 01 through 06.)
Examples: X-ray, cobalt, linear accelerator, neutron beam, betatron, spray radiation, intraoperative radiation, and stereotactic radiosurgery, such as gamma knife and proton beam, regardless of the source of the radiation.

2 Radioactive implants (Radiation treatment modality codes 07 through 12.)
Examples: Brachytherapy, interstitial implants, molds, seeds, needles, radioembolization, or intracavity applicators of radioactive materials, such as cesium, radium, radon, and radioactive gold.

3 Radioisotopes (Radiation treatment modality codes 13 through 16.)
Examples: Internal use of radioactive isotopes, such as iodine-131, phosphorus-32, strontium 89 and 90. Can be given orally, intracavitarily, or by intravenous injection.

4 Combinations of beam radiation (code 1) with radioactive implants (code 2) and/or radioisotopes (code 3)
The patient was treated with a combination of beam radiation and at least one of the two methods described by codes 2 and 3.

5 Radiation therapy, NOS - method or source not specified (Radiation treatment modality code 99.)

7 Patient or patient's guardian refused radiation therapy.

8 Radiation recommended, unknown if administered.

9 Unknown if radiation therapy recommended or performed; death certificate only cases. (Radiation treatment modality code 99.)

PHASE I EXTERNAL BEAM RADIATION PLANNING TECHNIQUE

Item Length: 2
Data Type: Numeric
ACoS: Required
State Registry: Required

NAACCR Item #1502

Description
This is a required 2-character field to record the external beam radiation planning technique used to administer the first phase of radiation treatment in the first course of treatment.

This item, in conjunction with *Phase I Radiation Treatment Modality*, replaces the historical *Regional Radiation Modality,* which converted to the two new radiation items upon upgrade to NAACCR v18 software. The items are required for all cases regardless of diagnosis year.

Codes and Descriptions

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed autopsy.
01	External beam, NOS	The treatment is known to be external beam, but there is insufficient information to determine the specific planning technique.
02	Low energy x-ray/photon therapy	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Energies are typically expressed in units of kilovolts (kV). These types of treatments are sometimes referred to as electronic brachytherapy of orthovoltage or superficial therapy. Clinical notes may refer to the brand names of low energy x-ray delivery devices, e.g., Axxent®, INTRABEAM®, or Esteya®.
03	2-D therapy	An external beam planning technique using 2-D imaging, such as plain film x-rays or fluoroscopic images, to define the location and size of the treatment beams. It should be clearly described as 2-D therapy. This planning modality is typically used only for palliative treatments.
04	Conformal or 3-D conformal therapy	An external beam planning technique using multiple, fixed beams shaped to conform to a defined target volume. It should be clearly described as conformal or 3-D therapy.
05	Intensity modulated therapy	An external beam planning technique where the shape or energy of beams is optimized using software algorithms. Any external beam modality can be modulated but these generally refer to photon or proton beams. Intensity modulated therapy can be described as intensity modulated radiation therapy (IMRT), intensity modulated x-ray or proton therapy (IMXT/IMPT), volumetric arc therapy (VMAT), and other ways. If a treatment is described as IMRT with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning.
06	Stereotactic radiotherapy or radiosurgery, NOS	Treatment planning using stereotactic radiotherapy/radiosurgery techniques, but the treatment is not described as Cyberknife® or Gamma Knife®. These approaches are sometimes described as SBRT (stereotactic body radiation), or SRT (stereotactic radiotherapy). If the treatment is described as robotic radiotherapy (e.g., Cyberknife®) or Gamma Knife®, use stereotactic radiotherapy subcodes below. If a treatment is described as stereotactic radiotherapy of radiosurgery with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning.

07	Stereotactic radiotherapy or radiosurgery, robotic	Treatment planning using stereotactic radiotherapy/radiosurgery techniques, which is specifically described as robotic (e.g., Cyberknife®).
08	Stereotactic radiotherapy or radiosurgery, Gamma Knife®	Treatment planning using stereotactic radiotherapy/radiosurgery techniques which uses a Cobalt-60 gamma ray source and is specifically described as Gama Knife®. This is most commonly used for treatments in the brain.
09	CT-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using a CT scan obtained at the treatment machine (online). These approaches are sometimes described as CT-guided online re-optimization or online re-planning. If a treatment is described as both CT-guided online adaptive therapy, as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as CT-guided online adaptive therapy. If a treatment is described as "adaptive" but does not include the descriptor "online, this code should not be used.
10	MR-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using an MRI scan obtained at the treatment machine (online). these approaches are sometimes described as MR-guided online re-optimization or online re-planning. If a treatment technique is described as both MR-guided online adaptive therapy as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as MR-guided online therapy. If a treatment is described as "adaptive" but does not include the descriptor "online," this code should not be used.
88	Not applicable	Treatment not by external beam.
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.

Instructions
Select the code for the radiation external beam treatment planning technique for the treatment the patient received as part of the first course of treatment. If necessary, obtain assistance from the radiation oncologist to determine the external beam treatment planning technique to ensure consistent coding.

a. Radiation external beam treatment planning technique will typically be found in the radiation oncologist's summary letter for the first course of treatment.
b. Use code 00, no radiation treatment, when diagnosed at autopsy.
c. Use code 04 for Conformal or 3-D Conformal Therapy whenever either is explicitly mentioned.
d. Use code 05 for Intensity Modulated Therapy (IMT) or Intensity Modulated Radiation Therapy (IMRT).
e. Do not use the "on-line adaptive therapy" codes if the treatment is described as "off-line adaptive" (The treatment plan is created while the patient is not on the delivery table.).
f. Use code 88 for brachytherapy or radioisotopes.
g. If code 98 is used, document the planning technique in text.

DATE OF RADIATION FLAG

Item Length: 2
Data Type: Numeric
ACoS: Required
NAACCR Item #1211 State Registry: Required

*Required if applicable for cases diagnosed 01/01/2015-12/31/2022

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Radiation Started* (NAACCR Item #1210). This data item was added to Volume II Version 12 (effective January 2010).

Rationale
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes
10 No information whatsoever can be inferred from this exceptional value. (It is unknown whether any radiation therapy administered.)
11 No valued date is applicable in this context (for example, no radiation therapy administered).
12 A valid date is applicable but not known. (Radiation therapy was administered but the date is unknown.)
15 Information is not available at this time, but it is expected that it will be available later. (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 *Date Radiation Started* (NAACCR Item #1210). The case was diagnosed between 2003 and 2009 and the *Date Radiation Started* was not recorded by the facility.

Instructions
a. Leave this item blank if the *Date Radiation Started* (NAACCR Item #1210). has a full or partial date recorded.
b. Use code 12 if the *Date Radiation Started* cannot be determined, but the patient did receive first course radiation.
c. Use code 10 if it is unknown whether any radiation was given.
d. Use code 11 if no radiation is planned or given.
e. Use code 15 if radiation is planned, but 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 the relevant radiation items.
f. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

Examples:

Description	Date (Leave unknown portions blank.)	Date of Radiation Flag
Full date known	*01/08/2021 or 2021/01/08	Blank
Month & year known	*01/_ _/2021 or 2021/01/_ _	Blank
Year only known	*_ _/_ _/2021 or 2021/_ _/_ _	Blank
Unknown if radiation given	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	10
No radiation given	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	11
Radiation given, date unknown	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	12
Radiation planned, not started yet	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	15

* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The WEBPLUS program uses the traditional format. The computer will store either in the interoperable format.

RADIATION/SURGERY SEQUENCE

Item Length: 1
Data Type: Numeric
ACoS: Required
State Registry: *Required

NAACCR Item #1380

*Required if available for cases diagnosed 01/01/2006 and later.

Description
This is a required 1-character field to record a code that indicates the sequencing of radiation and surgical procedures during the first course of treatment. Surgical procedures include *Surgical Procedure of Primary site*, *Scope of Regional Lymph Node Surgery*, and *Surgical Procedure/Other Site*.

Codes
0 No radiation therapy and/or surgical procedures
2 Radiation therapy before surgery
3 Radiation therapy after surgery
4 Radiation therapy both before and after surgery
5 Intraoperative radiation therapy
6 Intraoperative radiation therapy with other therapy administered before or after surgery
7 Surgery both before and after radiation
9 Sequence unknown, but both surgery and radiation therapy were given

Definitions

Code	Definition
0	No radiation therapy given or unknown if radiation 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 performed.
2	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 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	At least two courses of radiation therapy are given before and at least two more 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 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 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).
7	Radiation was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	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.

Instructions
a. If the patient did not receive both radiation therapy and surgery (one or a combination of the following surgical procedures: *Surgical Procedure of Primary Site, Regional Lymph Node Surgery* [codes 2-7], or *Surgical Procedure/Other Site*) during the first course of therapy, record code 0. Code 0 (no radiation therapy and or surgical procedures) includes the following types of cases:

(1) Patients who received neither radiation therapy nor surgery;
(2) Patients who received radiation therapy but no surgery;
(3) Patients who received surgery but were not treated with radiation therapy; or

(4) It is not known whether the patient received both surgery and radiation.

b. For patients who had both surgery and radiation, enter the code that describes the sequence in which the patient received radiation therapy and surgery during the first course of therapy. Code this item 2-9, as appropriate, 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* (excluding code 1)*,* or *Surgical Procedure/Other Site.*

   Code in the range of 2-9 only if the patient had both surgery and radiation therapy as first course treatment. Surgical Diagnostic and Staging Procedures (codes 01-09) do not qualify.

c. If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies. Assign code 4 when there are at least two courses, episodes, or fractions of radiation therapy given before and at least two more after surgery to the primary site, scope of regional lymph node surgery (excluding code 1), surgery to other regional site(s), distant site(s), or distant lymph node(s).

Codes with Examples:

0 Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain.

2 A large lung lesion was treated with 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.

REASON FOR NO RADIATION

NAACCR Item #1430

Item Length: 1
Data Type: Numeric
ACoS: Required
State Registry: *Required

*Required if available for cases diagnosed 01/01/2011 and later.

Description
This is a required 1-character field to record a code that indicates the reason no regional radiation therapy was administered to the patient.

Codes
0 Radiation therapy was administered.
1 Radiation therapy was not administered because it was not part of the planned first course treatment. Diagnosed at autopsy.
2 Radiation therapy was not recommended/administered because it was contraindicated based on other 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 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 was refused by the patient, the patient's family member, or the patient's guardian. The refusal was documented 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 only cases.

Instructions
1. If *Regional Treatment Modality* is coded 00 (not performed), record a code that indicates the reason based on patient record documentation.

2. Record code 1 if the treatment plan included multiple alternative treatment options and the patient selected treatment that did not include radiation therapy.

   Example: A patient is offered either surgery or brachytherapy to treat his stage 1 prostate and chooses surgical treatment. Record code 1 in *Reason for No Radiation.*

3. Record 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.

4. Record code 8 if it is known that a physician recommended radiation treatment, but no further documentation is available yet to confirm its administration.

5. Record code 8 to indicate referral to a radiation oncologist was made and the registry should follow to determine whither radiation was administered. If follow-up to the specialist or facility determines the patient was never there and no other documentation can be found, change the code to 1.

6. Cases coded to 8 should be followed and updated to a more definitive code as indicated.

7. Record code 9 if the treatment plan included multiple alternative treatment options, but it is unknown which treatment, if any, was provided.

CHEMOTHERAPY

Item Length: 2
Data Type: Numeric
ACoS: Required
State Registry: Required

NAACCR Item #1390

Description
This is a required 2-character field to record chemotherapy administered as first course of therapy. If chemotherapy was not administered, 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.

Record chemotherapy administered at your facility, as well as chemotherapy given at any other facilities, if known.

Codes
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 Multiagent chemotherapy administered as first course therapy.
82 Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (e.g., 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 the patient record.
87 Chemotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88 Chemotherapy was recommended, but it is unknown if it was administered.
99 It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in the patient record. Death certificate only.

Instructions
a. Select the code for the type of chemotherapy that the patient received as part of the first course of treatment, even if it is palliative. Record chemotherapy as cancer-directed therapy when it is delivered concurrently or as adjuvant treatment.

(1) Use 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.
(2) Use code 00 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include chemotherapy.
(3) Use code 00 if the option of, "no treatment," was accepted by the patient.
(4) Code chemoembolization as 01, 02, or 03 depending on the number of chemotherapeutic agents used.
(5) 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 it was not administered.
(6) Use code 87 if the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
(7) Use 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.
(8) Use code 88 to indicate referral was made medical oncologist and the registry must follow to determine whether it was given. If follow-up with the specific specialist or facility indicates the patient was never there, use code 00.
(9) Use 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.

(10) If chemotherapy was provided as a radiosensitizer or radioprotectant, do not code as chemotherapy treatment. Chemotherapy intended for radiosensitization or radioprotection is given in low doses that do not affect the cancer.
(11) If a chemotherapy drug is given for a reason other than cancer-directed treatment, do not code the drug as chemotherapy. If in doubt whether the chemotherapy drug is given to alleviate a symptom and not for cancer-directed treatment, consult your oncologist or oncology nurse.
(12) For facilities that collect *Palliative Care*: 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 provided in the *Palliative Care* NAACCR item #3270. The State Registry does not collect the *Palliative Care* item #3270.

b. In the *Chemotherapy* field, enter the code from the list above for the chemotherapy that the patient received. For WEBPLUS users, record the date the course of chemotherapy was started in the adjacent "Date" field.

Example: Single agent chemotherapy 5-FU was started on July 15, 2021 at a physician's office as part of the first course of treatment. The treatment would be entered as follows: Chemotherapy code 02, Date: 07/15/2021.

c. One planned course of chemotherapy may be given in several segments. These segments are recorded as one course. The date listed for that course of chemotherapy should be the date the first segment of that course began.

d. Two or more single agents given at separate times during the first course of cancer-directed therapy are considered a combination regimen and coded 03 (chemotherapy, multiple agents). If two or more single agents are given at different times after the first course, it is subsequent treatment and can be recorded in the "Subsequent Treatment" WEBPLUS screens. The State Registry does not collect subsequent treatment.

Chemotherapy Information and Definitions

a. Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) to determine whether the drugs used are classified as chemotherapeutic agents.

b. Chemotherapeutic agents may be administered by intravenous infusion or given orally. Other methods of administration include:

Intrathecal. Administered directly into the cerebrospinal fluid through a lumbar puncture needle into an implanted access device (Ommaya reservoir).
Pleural/pericardial. Injected directly into pleural or pericardial space to control malignant effusions.
Intraperitoneal. Injected into the peritoneal cavity.
Hepatic artery. Injected into a catheter inserted into the artery that supplies blood to the liver.

c. Chemotherapy agents may be administered singly or in a combination regimen of two or more chemotherapy drugs. They are administered in treatment cycles. The time span of a treatment cycle varies. It is dependent upon the histology, stage of disease, and treatment modalities. Chemotherapy may be administered for several weeks or several years.

d. Clarification of terms:
(1) ***Concurrent chemotherapy*** (multimodality therapy, combined modality therapy) is given before, during, or after other treatment modalities (surgery, radiation, etc.) as part of the treatment plan.

(2) ***Adjuvant chemotherapy*** is given after other methods have destroyed the clinically detectable cancer cells. Chemotherapy is given to destroy micrometastases (undetectable cancer cells). The intent is to prevent or delay a recurrence.

Example: A patient has breast cancer with positive nodes. All detectable tumor is removed by a modified radical mastectomy. The patient receives adjuvant chemotherapy to destroy any micrometastasis that may be present. The chemotherapy is given to delay or prevent a recurrence.

(3) ***Neoadjuvant therapy*** is given prior to surgical resection or radiation therapy to reduce the bulk of a locally advanced primary cancer.

Example: A patient with locally advanced breast cancer receives chemotherapy to reduce tumor size. Chemotherapy is followed by a modified radical mastectomy.

(4) ***Chemoembolization*** is a procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. Code as Chemotherapy when the embolizing agent(s) is a chemotherapeutic drug(s). Use *SEER*Rx Interactive Drug Database* (http:seer.cancer.gov/) to determine whether the drugs used are classified as chemotherapeutic agents.

Example: A patient with primary liver cancer is treated using the following procedure: Under x-ray guidance, a small catheter is inserted into an artery in the groin and the catheter tip is threaded into the artery in the liver that supplies blood flow to the tumor. Chemotherapy is injected through the catheter into the tumor and mixed with particles that embolize or block the flow of blood to the tumor.

(5) ***Ancillary drugs*** are medications whose actions are not directed at the patient's malignancy per se but that enhance the effects of the cancer-directed therapy. For example, ancillary drugs may modulate the actions of specific chemotherapeutic agents by increasing their effectiveness in destroying tumor cells or by decreasing the potential for specific side effects. Ancillary drugs are not to be coded as cancer-directed therapy.

Example: Folinic acid (leucovorin) stabilizes the drug-enzyme complex and thus increases the cytotoxic effects of 5-FU and is frequently administered with 5-FU for this purpose. Use chemotherapy code 02 (single agent) for 5-FU and leucovorin treatment.

e. Chemotherapy is divided into the following classifications:

Group	Subgroup(s)	Examples
Alkylating agents	Mustard gas derivatives/ nitrogen mustards	Mechlorethamine, Melphalan, Chlorambucil Cyclophosphamide, and Ifosfamide
	Ethylenimines	Thiotepa and Hexamethylmelamine
	Alkyl sulfonates	Busulfan
	Nitrosoureas	Carmustine, Lomustine, and Streptozotocin
	Hydrazines and Triazenes	Altretamine, Procarbazine, Dacarbazine, and Temozolomide
	Metal salts	Carboplatin, Cisplatin, Oxaliplatin
Antimetabolites	Folic acid antagonist	Methotrexate
	Pyrimidine antagonist	5-Fluorouracil (5-FU), Floxuridine, Cytarabine, Capecitabine, and Gemcitabine
	Purine antagonist	6-Mercaptopurine (6-MP) and 6-Thioguanine
	Adenosine deaminase inhibitor	Cladribine, Fludarabine, Nelarabine, and Pentostatin
Natural products	Antitumor antibiotics	Anthracyclines: Doxorubicin, Daunorubicin, Epirubicin, Mitoxantrone, and Idarubicin Chromomycins: Dactinomycin and Plicamycin Miscellaneous: Mitomycin and Bleomycin
	Plant alkaloids	Vinca alkaloids: Vinblastine, Vincristine, and Vinorelbine Taxanes: Paclitaxel and Docetaxel Podophyllotoxins: Etoposide and Teniposide Camptothecin analogs: Irinotecan and Topotecan

Group	Subgroup(s)	Examples
	Topoisomerase inhibitors	Topoisomerase I inhibitors: Irinotecan, Topotecan Topoisomerase II inhibitors: Amsacrine, Etoposide, Etoposide phosphate, and Teniposide
Miscellaneous agents		Ribonucleotide reductase inhibitor: Hydroxyrurea Adrenocortical steroid inhibitor: Mitotane Enzymes: Asparaginase and Pegaspargase Antimicrotubule agent: Estramustine Retinoids: Bexaratene, Isotretinoin, Tretinoin (ATRA)
Targeted therapy		A group of newer cancer drugs that act directly against abnormal proteins in cancer cells.

f. If the patient has an adverse reaction, the physician may change one of the drugs in a combination regimen. If the replacement drug belongs to the same group as the original drug, there is no change in the regimen.

Example: The physician documents a multimodality treatment plan that includes a combination regimen of chemotherapy. Vinblastine is one of the drugs in the chemotherapy regimen. After two cycles of chemotherapy, the physician says the Vinblastine will be replaced with Vincristine and the chemotherapy will continue as planned. This is a continuation of the planned first course of therapy.

If the replacement drug is in a different group than the original drug, it is subsequent therapy.

Exception: Unless there is disease progression, neoadjuvant chemotherapy and all subsequent planned first course of treatment would be recorded as first course, even if there is a change in chemotherapeutic agents and/or groups.

g. Code the six drugs listed below as BRM, beginning with January 1, 2013 diagnoses. Continue to code cases diagnosed prior to 01/01/2013 as chemotherapy.

Alemtuzumab/Campath
Bevacizumab/Avastin
Rituximab/Rituxan
Trastuzumab/Herceptin
Pertuzumab/Perjeta
Cetuximab/Erbitux

DATE OF CHEMOTHERAPY FLAG

Item Length: 2
Data Type: Numeric
ACoS: Required
NAACCR Item #1221
State Registry: Required

*Required if applicable for cases diagnosed 01/01/2015-12/31/2022

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Chemotherapy Started* (NAACCR Item #1220). This data item was added to Volume II Version 12 (effective January 2010).

Rationale
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes
10 No information whatsoever can be inferred from this exceptional value. (It is unknown if chemotherapy was administered.)
11 No proper value is applicable in this context (for example, no chemotherapy was administered).
12 A valid date is applicable but not known. (Chemotherapy was administered but the date is unknown.)
15 Information is not available at this time, but it is expected that it will be available later. (Chemotherapy 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 *Date Chemotherapy Started* (NAACCR Item #1220) or the date was not expected to have been transmitted. The case was diagnosed between 2003 and 2009 and the *Date Chemotherapy Started* was not recorded by the facility.

Instructions
a. Leave this item blank if the *Date Chemotherapy Started* has a full or partial date recorded.
b. Use code 12 if the *Date Chemotherapy Started* cannot be determined, but the patient did receive first course chemotherapy.
c. Use code 10 if it is unknown whether any chemotherapy was administered.
d. Use code 11 if no chemotherapy is planned or given.
e. Use 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.
f. Code this data item (when appropriate) even if your software uses the traditional format for date entry.
g. Leave this item blank for diagnoses between 2003 and 2009 if your facility did not collect *Date Chemotherapy Started* at that time.

Examples:

Description	Date (Leave unknown portions blank.)	Date of Chemo Flag
Full date known	*01/08/2021 or 2021/01/08	Blank
Month & year known	*01/_ _/2021 or 2021/01/_ _	Blank
Year only known	*_ _/_ _/2021 or 2021/_ _/_ _	Blank
Unknown if chemo given	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	10
No chemo given	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	11
Chemo given, date unknown	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	12
Chemo planned, not started yet	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	15

* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The WEBPLUS program uses the traditional format. The computer will store either in the interoperable format.

SYSTEMIC/SURGERY SEQUENCE

Item Length: 1
Data Type: Numeric
ACoS: Required
NAACCR Item #1639
State Registry: *Required

***Required for cases diagnosed 01/01/2006 and later.**

Description
This is a required 1-character field in the WEBPLUS abstract screen to record a code that indicates the sequencing of systemic therapy and surgical procedures provided as part of the first course of treatment.

For the purpose of coding systemic treatment sequence with surgery, "surgery" is defined as any one or a combination of the following:

- Surgical Procedure of Primary Site (codes 10-90) or
- Scope of Regional Lymph Node Surgery (codes 2-7) or
- Surgery to other regional site(s), distant site(s), or distant lymph node(s) (codes 1-5).

Systemic therapy is defined as:

- Chemotherapy
- Hormone therapy
- Biological response therapy/immunotherapy
- Bone marrow transplant
- Stem cell harvests
- Surgical and/or radiation endocrine therapy

Codes
0 No systemic therapy and/or surgical procedures; unknown if surgery and/or systemic therapy given
2 Systemic therapy before surgery
3 Systemic therapy after surgery
4 Systemic therapy both before and after surgery
5 Intraoperative systemic therapy
6 Intraoperative systemic therapy with other therapy administered before or after surgery
7 Surgery both before and after systemic therapy
9 Sequence unknown, but both surgery and systemic therapy were given

Definitions

Code	Definition
0	No systemic therapy was given and/or no surgery defined above was performed. It is unknown whether both surgery and systemic treatment were provided.
2	Systemic therapy was given before any surgery defined above was performed. Note: Both treatments must be coded.
3	Systemic therapy was given after any surgery defined above was performed. Note: Both treatments must be coded.
4	At least two courses of systemic therapy were given before and at least two more after any surgery defined above was performed. Note: Both the surgery and the systemic treatments must be coded.
5	Intraoperative systemic therapy was given during any surgery defined above. Note: Both treatments must be coded.
6	Intraoperative systemic therapy was given during any surgery defined above with other systemic therapy administered before or after surgery. Note: Both treatments must be coded.
7	Systemic therapy was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	The patient had systemic therapy and surgery and the sequence of the treatments is not stated in the patient record. Note: Both treatments must be coded.

Instructions

a. Code *Systemic/Surgery Sequence* for patients diagnosed on or after January 1, 2006.

b. Code the administration of systemic therapy in sequence with the first surgery performed.

c. If the patient did not receive both systemic therapy and surgery (one or a combination of the following surgical procedures: *Surgical Procedure of Primary Site*, *Scope of Regional Lymph Node Surgery* [codes 2-7], and *Surgical Procedure/Other Site*) during the first course of therapy, record code 0. Code 0 (no systemic therapy and or surgical procedures) includes the following types of cases:

   (1) Patients who received neither systemic therapy nor surgery;
   (2) Patients who received systemic therapy but no surgery;
   (3) Patients who received surgery but were not treated with systemic therapy; or
   (4) It is not known whether the patient received both surgery and systemic therapy.

d. If the patient received both systemic therapy and any one or a combination of the following surgical procedures: *Surgical Procedure of Primary Site*, *Scope of Regional Lymph Node Surgery* (excluding code 1), and *Surgical Procedure/Other Site*, then code this item 2-9, as appropriate.

e. If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies. For example: Use code 4 for chemotherapy then surgery then hormone therapy then surgery.

Codes with Examples:

0 Due to other medical conditions surgery was not performed. The patient refused other treatment.

0 A patient with lobular carcinoma in situ of the breast underwent an excisional biopsy. No chemotherapy was recommended.

0 A patient with small cell carcinoma of the lung was treated with VP-16 and carboplatin.

2 A patient with prostate cancer received hormone therapy prior to a radical prostatectomy.

3 A patient underwent a colon resection followed by a 5-FU based chemotherapy regimen.

3 A patient has a lymph node dissection, followed by chemotherapy, followed by primary site surgery.

4 A patient with breast cancer receives pre-operative chemotherapy followed by post-operative Tamoxifen.

5 A patient with an intracranial primary undergoes surgery at which time a glial wafer is implanted into the resected cavity.

6 A patient with metastatic colon cancer receives intraoperative chemotherapy to the liver followed by postoperative chemotherapy.

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.

DATE SYSTEMIC THERAPY STARTED

Item Length: 8
Data Type: Numeric
ACoS: Required
NAACCR Item #3230
State Registry: Required

Description
This is a required 8-character field for recording the date of initiation for systemic therapy that is part of the first course of treatment. Systemic therapy includes the administration of chemotherapy agents, hormonal agents, biological response modifiers, bone marrow transplants, stem cell harvest, and surgical and/or radiation endocrine therapy.

Codes

	Month	Day	Year
01	January	01	Use four-digit year (e.g., 2021)
02	February	02	blank = Year unknown
03	March	03	
04	April	...	
05	May	...	
06	June	25	
07	July	26	
08	August	...	
09	September	30	
10	October	31	
11	November	blank = Day unknown	
12	December		
blank	Month unknown		

Instructions

a. Record the first or earliest date on which systemic therapy was administered. Systemic therapy includes *Chemotherapy, Hormone Therapy, Immunotherapy,* and *Hematologic Transplant and Endocrine Procedures*. Determine whether your software vendor uses the traditional format for date entry (MMDDCCYY) or the interoperable format (CCYYMMDD). The WEBPLUS program uses the traditional format.

b. Record the month, day, and year (MM/DD/CCYY) the systemic therapy was started. Fill in with leading zeros where needed. For example, record June 3, 2021 as 06/03/2021.

c. If the exact date of the beginning of systemic therapy is not available, record an approximate date. If information is limited to a description, use the following:

DESCRIPTIVE TERM USED	DATE CODE
Spring	April
The middle of the year	July
Fall	October
Winter	Try to determine if this means the beginning of the year (January) or the end of the year (December). Code as indicated.

d. Do not record the date of initiation of *Other Treatment* in this field, even if it is the only treatment administered.

Examples:

12152020 A patient with breast cancer begins her regimen of chemotherapy on December 15, 2020, and is subsequently given tamoxifen on January 20, 2021.

06022021	A patient with Stage IV prostate cancer has an orchiectomy on June 2, 2021. The patient is then started on a regime of hormonal agents on June 9, 2021.
09_ _2021	If the exact date of the beginning of treatment is not available, record an approximate date. For example, September 2021.
04_ _2021	The information is limited to the description “Spring” of 2021.
07_ _2021	The information is limited to the description “The middle of the year,” 2021.
10_ _2021	The information is limited the description “Fall” of 2021.
12_ _2020 or 01_ _2021	The information is limited to the description “Winter.” Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

RX DATE SYSTEMIC FLAG

Item Length: 2
Data Type: Numeric
ACoS: Required
State Registry: Required

NAACCR Item #3231

*Required if applicable for cases diagnosed 01/01/2015-12/31/2022

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Systemic Therapy Started* (NAACCR Item #3230). This data item was added to Volume II Version 12 (effective January 2010).

Rationale
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes
10 No information whatsoever can be inferred from this exceptional value. It is unknown whether systemic therapy was administered.
11 A valid date is not applicable in this context. No systemic therapy was administered.
12 A valid date is applicable but not known. Systemic therapy was administered but the date is unknown.
15 Information is not available at this time, but it is expected that it will be available later. Systemic therapy 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 is coded in the *Date Systemic Therapy Started* (NAACCR Item #3230).

Instructions
a. Leave this item blank if *Date Systemic Therapy Started* has a full or partial date recorded.
b. Use code 12 if the *Date Systemic Therapy Started* cannot be determined, but the patient did receive first course systemic therapy.
c. Use code 10 if it is unknown whether any systemic therapy was administered.
d. Use code 11 if no systemic therapy is planned or administered.
e. Use code 15 if systemic therapy is planned, but not yet started.
f. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

Examples:

Description	Date (Leave unknown portions blank.)	Date of 1st Crs Rx Flag
Full date known	*01/08/2021 or 2021/01/08	Blank
Month & year known	*01/_ _/2021 or 2021/01/_ _	Blank
Year only known	*_ _/_ _/2021 or 2021/_ _/_ _	Blank
Unknown if Rx given	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	10
Diagnosed at autopsy	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	11
Rx given, unknown date	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	12
RX planned, not yet started	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	15

* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The WEBPLUS program uses the traditional format. The computer will store either in the interoperable format.

HORMONE THERAPY
(HORMONE/STEROID [ENDOCRINE] THERAPY)

NAACCR Item #1400

Item Length: 2
Data Type: Numeric
ACoS: Required
State Registry: Required

Description
This is a required 2-character field to record hormone or steroid (endocrine) therapy administered as part of the first course of treatment. If hormone therapy was not administered, this item records the reason it was not administered. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth and includes hormones, antihormones, and steroids.

Record hormone therapy administered at your facility, as well as hormone therapy given in any other facilities, if known.

Codes
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 (e.g., 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 the 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 documented in the patient record.
88 Hormone therapy was recommended, but it is unknown if it was administered.
99 If is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in the patient record. Death certificate only.

Definitions
a. Hormones promote hormonal withdrawal or hormonal interface to alter the growth of cancer. Hormone therapy may effect a long-term control of the cancer growth. It is not usually used as a curative measure.

   Hormone categories are:
   - Androgens: fluoxymesterone (Halotestin, Androxy)
   - Anti-androgens: bicalutamide (Casodex), flutamide (Eulexin), and nilutamide (Nilandron)
   - Corticosteroids, Adrenocorticotropic agents: prednisone and dexamethasone (Decadron)
   - Estrogen: diethylstilbestrol (DES)
   - Progestins: Provera and Megace
   - Estrogen antagonists, Anti-estrogens: tamoxifen (Nolvadex), fulvestrant (Faslodex), toremifene (Fareston)
   - Aromatase inhibitors, Antiaromatase: anastrozole (Arimidex), exemestane (Aromasin), letrozole (Femara)
   - Gonadotropin releasing hormones (GnRH) and Luteinizing-hormone-releasing hormones (LH-RH): leuprolide (Lupron) and goserelin (Zoladex)
   - Thyroid hormones: levothyroxine (Synthroid) and liothyronine (Cytomel)

b. Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) to determine whether the drugs used are classified as hormone therapy.

c. Adrenocorticotropic hormones (cancer-directed only) are coded for leukemias, lymphomas, multiple myelomas, breast, and prostate cancer.

Instructions

a. Record code 01 if the patient received hormone therapy as part of the first course of treatment, even if it is palliative. Administration of hormones or antihormones (cancer-directed only) should be recorded for all primary and metastatic sites.

(1) Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).
(2) Code 01 for thyroid replacement therapy that inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.
(3) Do not code hormone drugs as hormone therapy when administered for reasons other than chemotherapeutic treatment. Examples:
- Hormone drug used to alleviate symptoms (e.g., Solu-Medrol used to control vomiting; Decadron to reduce edema and relieve neurological symptoms from brain metastasis in a lung primary.) Do not code as hormone therapy.
- Hormone replacement therapy used when tumor involvement or cancer-directed treatment has destroyed hormone-producing tissue. Do not code as hormone therapy.

(4) For facilities that collect *Palliative Care*: 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 provided in the *Palliative Care* NAACCR item #3270. The State Registry does not collect the *Palliative Care* item #3270.

b. Record code 00:
(1) 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;
(2) If the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include hormone therapy; or
(3) If the option of, "no treatment," was accepted by the patient.

c. 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 it was not administered.

d. Use 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.

e. Use code 88:
(1) If it is known that a physician recommended hormone therapy, but no further documentation is available yet to confirm its administration; or
(2) To indicate referral was made medical oncologist and the registry must follow to determine whether hormone therapy was given. If follow-up with the specific specialist or facility indicates the patient was never there, use code 00.

f. Use 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.

g In the *Hormone Therapy* field, record 01 for hormone therapy. For WEBPLUS users, record the date the course of hormone therapy was started in the adjacent "Date" field.

Example: Tamoxifen was started on July 15, 2021. The treatment would be entered as follows: Hormone Therapy code 01, Date: 07/15/2021.

Codes with Examples:

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 antiandrogen).

87 A patient with metastatic prostate cancer declines the administration of Megace (a progestin) and the refusal is noted in the patient record.

DATE OF HORMONE THERAPY FLAG

Item Length: 2
Data Type: Numeric
ACoS: Required
NAACCR Item #1231 State Registry: Required

*Required if applicable for cases diagnosed 01/01/2015-12/31/2022

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Hormone Therapy Started* (NAACCR Item #1230). This data item was added to Volume II Version 12 (effective January 2010).

Rationale
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes
10 No information whatsoever can be inferred from this exceptional value. (It is unknown if any hormone therapy was administered.)
11 No valid date is applicable in this context. (No hormone therapy was administered.)
12 A valid date is applicable but not known. (Hormone therapy was administered but the date is unknown.)
15 Information is not available at this time, but it is expected that it will be available later (Hormone 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 *Date Hormone Therapy Started* (NAACCR Item #1230). The case was diagnosed between 2003 and 2009 and the *Date Hormone Therapy Started* was not recorded by the facility.

Instructions
a. Leave this item blank if the *Date Hormone Therapy Started* has a full or partial date recorded.
b. Use code 12 if the *Date Hormone Therapy Started* cannot be determined, but the patient did receive first course hormone therapy.
c. Use code 10 if it is unknown whether any hormone therapy was administered.
d. Use code 11 if no hormone therapy is planned or given.
e. Use code 15 if hormone therapy is planned, but not yet started. Follow this patient for chemotherapy and update this item, *Date Hormone Therapy Started*, and the relevant hormone therapy items.
f. Code this data item (when appropriate) even if your software uses the traditional format for date entry.
g. Leave this item blank for diagnoses between 2003 and 2009 if your facility did not collect *Date Hormone Therapy Started* at that time.

Examples:

Description	Date (Leave unknown portions blank.)	Date of Hormone Rx Flag
Full date known	*01/08/2021 or 2021/01/08	Blank
Month & year known	*01/_ _/2021 or 2021/01/_ _	Blank
Year only known	*_ _/_ _/2021 or 2021/_ _/_ _	Blank
Unknown if hormone Rx given	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	10
No hormone Rx given	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	11
Hormone Rx given, date unknown	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	12
Hormone Rx planned, not started yet	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	15

* For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The WEBPLUS program uses the traditional format. The computer will store either in the interoperable format.

IMMUNOTHERAPY
(BIOLOGICAL RESPONSE MODIFIER [BRM] THERAPY)

NAACCR Item #1410

Item Length: 2
Data Type: Numeric
ACoS: Required
State Registry: Required

Description
This is a required 2-character field to record immunotherapy or Biological Response Modifier (BRM) therapy administered as part of the first course of treatment. Record immunotherapy administered at your facility, as well as immunotherapy given in any other facilities, if known.

Codes
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 (e.g., 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 the patient record.
87 Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88 Immunotherapy was recommended, but it is unknown if it was administered.
99 It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in the patient record. Death certificate only.

Definitions
a. Immunotherapy (BRM) consists of biological or chemical agents that alter the immune system or change the host's response (defense mechanism) to the tumor cells.

b. Examples of immunotherapy (BRM) agents are:

- Aldara
- Allogenic cells
- BCG
- C-Parvum
- Interferon
- Ontak
- Interleukin (IL-2)
- Levamisole
- MVE-2
- Thymosin
- TNF (Tumor Necrosis Factor)
- Vaccine therapy

Note: Monoclonal antibodies (Mab) are used in various ways as systemic therapy and can be categorized as chemotherapy, immunotherapy, or ancillary drugs. Use the *SEER* reference cited below to identify the treatment category in which each monoclonal antibody should be coded.

c. Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) to determine whether the drugs used are classified as immunotherapy (BRM).

Instructions
a. Record code 01 if immunotherapy (BRM) was administered, even if it is palliative, and determine the date it was started.

b. Use 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;
If the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include immunotherapy; or
If the option of, "no treatment," was accepted by the patient.

c. 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 it was not administered.

d. Use code 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

e. Use code 88:
   (1) If it is known that a physician recommended immunotherapy, but no further documentation is available yet to confirm its administration; or
   (2) To indicate referral was made medical oncologist and the registry must follow to determine whether immunotherapy was given. If follow-up with the specific specialist or facility indicates the patient was never there, use code 00.

f. Use 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 is was recommended or administered.

g. In the *Immunotherapy* field, record code 01 for immunotherapy (BRM). For WEBPLUS users, record the date the course of immunotherapy was started in the adjacent "Date" field.

   Example: Interferon was started on July 15, 2021. The treatment would be entered as follows: Immunotherapy code 01, Date: 07/15/2021.

   For facilities that collect *Palliative Care*: 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 provided in the *Palliative Care* NAACCR item #3270. The State Registry does not collect the *Palliative Care* item #3270.

h. Code the six drugs listed below as BRM, beginning with January 1, 2013 diagnoses. Continue to code cases diagnosed prior to 01/01/2013 as chemotherapy.

   Alemtuzumab/Campath
   Bevacizumab/Avastin
   Rituximab/Rituxan
   Trastuzumab/Herceptin
   Pertuzumab/Perjeta
   Cetuximab/Erbitux

DATE OF IMMUNOTHERAPY (BRM) FLAG

Item Length: 2
Data Type: Numeric
ACoS: Required
NAACCR Item #1241
State Registry: Required

*Required if applicable for cases diagnosed 01/01/2015-12/31/2022

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Immunotherapy Started* (NAACCR Item #1240). This data item was added to Volume II Version 12 (effective January 2010).

Rationale
Prior to version 12 (through 2009 diagnosis), date fields included codes which provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date
information that had previously been transmitted in date fields.

Codes
10 No information whatsoever can be inferred from this exceptional value. (It is unknown if immunotherapy was administered.)
11 No valid date is applicable in this context (for example, no immunotherapy was administered).
12 A valid date is applicable but not known. (Immunotherapy administered but the date is unknown.)
15 Information is not available at this time, but it is expected that it will be available later. (Immunotherapy 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 is coded in the *Date Immunotherapy Started* item (NAACCR Item #1240. The case was diagnosed between 2003 and 2009 and the *Date Immunotherapy Started* was not recorded by the facility.

Instructions
a. Leave this item blank if the *Date Immunotherapy Started* has a full or partial date recorded.
b. Use code 12 if the *Date Immunotherapy Started* cannot be determined, but the patient did receive first course immunotherapy or a biologic response modifier.
c. Use code 10 if it is unknown whether any immunotherapy or biologic response modifier was administered.
d. Use code 11 if no immunotherapy or biologic response modifier is planned or given.
e. Use 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.
f. Code this data item (when appropriate) even if your software uses the traditional format for date entry.
g. Leave this item blank for diagnoses between 2003 and 2009 if your facility did not collect *Date Immunotherapy Started* at that time.

Examples:

Description	Date (Leave unknown portions blank.)	Date of BRM Flag
Full date known	*01/08/2021 or 2021/01/08	Blank
Month & year known	*01/_ _/2021 or 2021/01/_ _	Blank
Year only known	*_ _/_ _/2021 or 2021/_ _/_ _	Blank
Unknown if BRM given	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	10
No BRM given	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	11
BRM given, date unknown	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	12
BRM planned, not started yet	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	15

***** For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The WEBPLUS program uses the traditional format. The computer will store either in the interoperable format.

HEMATOLOGIC TRANSPLANT AND ENDOCRINE PROCEDURE

NAACCR Item #3250

Item Length: 2
Data Type: Numeric
ACoS: Required
State Registry: Required

Description
This is a required 2-character field to record any systemic therapeutic *procedures* administered as part of the first course of treatment at this and all other facilities. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy. If none of these *procedures* were administered, then use this field to record the reason they were not performed.

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

Codes
00 No transplant procedure or endocrine therapy was administered as part of first course therapy; diagnosed at autopsy.
10 A bone marrow transplant procedure was administered, but the type was not specified.
11 Bone marrow transplant - autologous.
12 Bone marrow transplant - allogeneic.
20 Stem cell harvest and infusion; umbilical cord stem cell transplant with blood from one or multiple umbilical cords.
30 Endocrine surgery and/or endocrine radiation therapy.
40 Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of procedures coded as 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 (e.g., 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 was not administered as part of the first course of therapy. No reason was stated in the 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 the patient record.
88 Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered.
99 It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in the patient record. Death certificate only.

Definitions
a. Bone marrow transplant (BMT): A procedure used to restore stem cells that were destroyed by chemotherapy and/or radiation.

Autologous BMT: "Auto" means "self." Stem cells are removed from the patient before high-dose chemotherapy or radiation treatment is administered. After these treatments are done, the patient's own stem cells are reinfused to restore the destroyed cells.

Allogeneic BMT: "Allo" means "other." Stem cells are removed from another person, called a donor. Most times, the donor must have the same genetic makeup as the patient, so that their blood is a "match." A relative may be a good match or donors who are not related to the patient may be found through national bone marrow registries. Bone marrow transplanted from an identical twin (syngeneic BMT) is coded as an allogeneic BMT.

b. 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.

c. Endocrine irradiation and/or endocrine surgery are procedures that 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.

Instructions

a. Select the code for the type of procedure the patient received and determine the date it was performed.

(1) Use 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;
- If the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include a transplant or endocrine procedure; or
- If the option of, "no treatment," was accepted by the patient.

(2) Use code 10 if the patient has "mixed chimera transplant" (mini-transplant or non-myeloablative transplant). These transplants are a mixture of the patient's cells and donor cells.

(3) Use code 20 if the patient has a stem cell harvest followed by a rescue or reinfusion (stem cell transplant, including allogenic stem cell transplant) as first course therapy. If the patient does not have a rescue, code the stem cell harvest as 88, recommended, unknown if administered.

(4) 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 it was not administered.

(5) Use code 87 if the patient refused a recommended transplant or endocrine procedure, or made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

(6) Use code 88:
- If it is known that a physician recommended transplant or endocrine procedure, but no further documentation is available yet to confirm its administration.
- If a bone marrow or stem cell harvest was undertaken, but was not followed by a rescue or re-infusion as part of first course treatment; or
- To indicate referral was made to a specialist for hematologic transplant or endocrine procedures and the registry must follow the case. If follow-up with the specific specialist or facility indicates the patient was never there, use code 00.

(7) Use 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 is was recommended or administered.

b. In the *Hematologic Transplant and Endocrine Procedure* field, enter the code from the list above for the procedure that the patient received. For WEBPLUS users, record the date the procedure was performed in the adjacent "Date" field.

For facilities that collect *Palliative Care*: 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 procedure provided in the *Palliative Care* NAACCR item #3270. The State Registry does not collect the *Palliative Care* item #3270.

OTHER TREATMENT

Item Length: 1
Data Type: Numeric
ACoS: Required
State Registry: Required

NAACCR Item #1420

Description
This is a required 1-character field to record cancer-directed treatment that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual. Record the therapy delivered at your facility, as well as other therapy given in any other facilities, if known.

Codes and Definitions

Codes	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 therapy).
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 which is 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.

Instructions

a. Select the code for other treatment received by the patient as part of the first course of treatment.

b. In the *Other Treatment* field, enter the code from the list above for the "other" therapy that the patient received, even if it is palliative. For WEBPLUS users, record the date the course of other therapy was started in the adjacent "Date" field.

(1) Use code 0 for any of the following:
- There is no information in the patient's medical record about other therapy and it is known that other therapy is not usually performed for this type and/or stage of cancer or there is no reason to suspect that the patient would have had other therapy.
- The treatment plan offered multiple options and the patient selected treatment that did not include other therapy.
- The patient elects to pursue no treatment following the discussion of other therapy. (Discussion does not equal a recommendation.)
- The patient is diagnosed at autopsy.

(2) Use code 1 for any of the following:
- Embolization using alcohol as an embolizing agent;
- Embolization to a site other than the liver where the embolizing agent is unknown;
- PUVA (psoralen and long-wave ultraviolet radiation);
- Peptide receptor radionuclide therapy (PRRT).

Note: Do not code presurgical embolization performed to shrink the tumor and make resection of the primary tumor easier. Examples where presurgical embolizations may be used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

(3) Use code 1 for supportive care (e.g., phlebotomy, transfusion, or aspirin) used in the treatment of only certain hematopoietic diseases. Consult the most recent version of the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* for instructions for coding care of specific hematopoietic neoplasms in this item.

(4) Use code 6 for the following:
- Unconventional methods whether they are the only therapy or are given in combination with conventional therapy (complementary medicine).
- Alternative therapy **only** if the patient receives no other type of treatment.

c. Do not code ancillary drugs (defined in the chemotherapy section of this manual) in this field. There is no coding scheme for ancillary drugs.

Examples of ancillary drugs:
Allopurinol
G-CSF (growth stimulating factors)
Epogen
Leucovorin
Neupogen

This a partial list. Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) if in doubt as to which drugs are ancillary drugs and not coded.

d. Do not code supportive care, observation, or any treatment that does not meet the usual definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue."
Exception: For specific hematopoietic diseases as instructed in the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual*.

Definitions

a. Complementary and Alternative Medicine (CAM): any medical system, practice, or product that is not thought of as standard medicine (conventional medicine). CAM treatments may include dietary supplements, megadose vitamins, herbal preparations, acupuncture, massage therapy, magnet therapy, spiritual healing, and meditation. Complementary medicine is used along with standard medicine. Alternative medicine is used in place of standard treatment.

b. Phlebotomy may be called blood removal, bloodletting, or venesection.

c. Transfusions may include whole blood, RBCs, platelets, platelet pheresis, fresh frozen plasma (FFP), plasmapheresis, and cryoprecipitate.

DATE OF OTHER TREATMENT FLAG

Item Length: 2
Data Type: Numeric
ACoS: Required
NAACCR Item #1251 State Registry: Required

*Required if applicable for cases diagnosed 01/01/2015-12/31/2022

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Other Treatment Started* (NAACCR Item #1250). This data item was added to Volume II Version 12 (effective January 2010).

Rationale
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes
10 No information whatsoever can be inferred from this exceptional value. (It is unknown if other therapy was administered.)
11 No valid date is applicable in this context (for example, no other treatment was administered).
12 A valid date is applicable but not known. (Other therapy administered but the date is unknown.)
15 Information is not available at this time, but it is expected that it will be available later. (Other 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 *Date Other Treatment Started* (NAACCR Item #1250). The case was diagnosed between 2003 and 2009 and the *Date Other Treatment Started* was not recorded by the facility.

Instructions
a. Leave this item blank if the *Date Other Treatment Started* (NAACCR Item #1250) has a full or partial date recorded.
b. Use code 12 if the *Date Other Treatment Started* cannot be determined, but the patient did receive first course other treatment.
c. Use code 10 if it is unknown whether any other treatment was administered. (The *Other Treatment* item is coded 9.)
d. Use code 11 if no other treatment is planned or given. (The *Other Treatment* item is coded 0, 7, or 8.)
e. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

Examples:

Description	Date (Leave unknown portions blank.)	Date of Other Rx Flag
Full date known	*01/08/2021 or 2021/01/08	Blank
Month & year known	*01/_ _/2021 or 2021/01/_ _	Blank
Year only known	*_ _/_ _/2021 or 2021/_ _/_ _	Blank
Unknown if other Rx given	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	10
No other Rx given	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	11
Other Rx given, date unknown	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	12

***** For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The WEBPLUS program uses the traditional format. The computer will store either in the interoperable format.

DESCRIPTION OF TREATMENT

Data Type: Text
ACoS: N/A
State Registry: Required

Description
This is required text for recording narrative descriptions of all treatment given for the tumor being reported, whether treatment is to the primary or metastatic site. In the paper abstract, the *Description of Treatment* field is a single field for recording all types of treatment. The WEBPLUS abstract screen provides a separate text field for each treatment modality. Facilities using other types of registry software should follow their vendor's instructions for recording treatment text. *ISCR will no longer accept paper abstracts beginning 1/1/2026

Rationale
Text is needed to justify the codes selected for the data items and to record information that is not coded at all. The text is used for quality control and special studies.

Instructions
RX Text-Surgery
a. Record information describing all surgical procedures performed as part of treatment.
b. Include, as applicable: Date of each procedure; facility where each procedure was performed; type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites; lymph nodes removed; regional tissues removed; metastatic sites; and positive and negative findings.

Example: 01/01/2025 ABC Hospital, Dr Jon Doe, Right Hemicolectomy, 15 nodes removed, margins neg.

RX Text-Radiation (Beam)
a. Record information regarding treatment of the tumor with beam radiation.
b. Include, as applicable: Date radiation treatment began; facility where treatment was given; type(s) of beam radiation (e.g., orthovoltage, cobalt 60, MV x-rays, electrons, mixed modalities); and other treatment information (e.g., patient discontinued after five treatments).

Example: 01/01/2025-01/15/2025 ABC Radiation Oncology, Dr Mary Doe, Phase 1: Lung, IMRT, Photons, 180cGy per fx, 10 fxs, total of 1800cGy.

RX Text-Radiation Other
a. Record information regarding treatment of the tumor with radiation other than beam radiation. This includes brachytherapy and systemic radiation therapy.
b. Include, as applicable: Date treatment began; facility where treatment was given; type(s) of non-beam radiation (e.g., high dose rate brachytherapy, seed implant, radioisotopes [I-131]); and other treatment information.

Example: 01/01/2025-01/10/2025 ABC Radiation Oncology, Dr Mary Doe, HDR Brachytherapy to Vagina, 4800cGy in 5 fxs, 960cGy per fx.

RX Text-Chemotherapy
a. Record information regarding chemotherapy treatment of the tumor.
b. Include, as applicable: Date chemotherapy began; facility where chemotherapy was given; type of chemotherapy (e.g., name of agent(s) or protocol); and other treatment information (e.g., treatment cycle incomplete).

Example: 01/01/2025 ABC Medical Oncology, Dr Michael Rogers, Gemcitabine and Doxorubicin initiated.

RX Text-Hormone
a. Record information about hormonal cancer-directed treatment.
b. Include, as applicable: Date treatment began; facility where treatment was given; type of hormone or antihormone agent(s) (e.g., Tamoxifen); type of endocrine surgery or radiation (e.g., orchiectomy); and other treatment information (e.g., treatment cycle incomplete).

Example: 01/01/2025 ABC Surgical Oncology, Dr Sandy Shores, Tamoxifen initiated. Patient switched to Anastrozole on 4/1/2025.

RX Text-BRM
a. Record information regarding the treatment of the tumor with biological response modifiers or immunotherapy.

b. Include, as applicable: Date treatment began; facility where treatment was given; type of BRM agent (e.g., Interferon, BCG); BRM procedures (e.g., bone marrow transplant, stem cell transplant); and other treatment information (e.g., treatment cycle incomplete).

Example: 01/01/2025 ABC Medical Oncology, Dr Michael Rogers, Keytruda initiated in 1st course.

RX Text-Other

a. Record information treatment that cannot be defined as one of the other treatment modalities. This includes experimental and blinded clinical trials.
b. Include, as applicable: Date treatment began; facility where treatment was given; type of treatment (e.g., blinded clinical trial, hyperthermia); and other treatment information (e.g., treatment cycle incomplete).

Example: 01/01/2025 ABC University Hospital, Stem Cell Transplant, Autologous
Example: 01/01/2025 ABC Medical Oncology, Aspirin initiated

DATE OF LAST CONTACT OR DEATH

Item Length: 8
Data Type: Numeric
ACoS: Required
State Registry: Required

NAACCR Item #1750

Description
This is a required 8-character field to record the date of last contact (DLC). If the patient is dead, this field records the date of death. Determine whether your software vendor uses the traditional format for date entry (MMDDCCYY) or the interoperable format (CCYYMMDD). The WEBPLUS program uses the traditional format.

Definition
This date may be the discharge date, date of death, date of a patient's visit to a doctor's office or clinic, or the date the patient was last contacted, whichever is the most recent. This date must be the latest date in the record. For example, a treatment date cannot be later than the *Date of Last Contact*.

Instructions

a. If no information is known after the patient is discharged from your hospital, record the date of discharge or the date of the patient's last outpatient visit. When abstracting a case with more than one admission or clinic visit, make sure the date of last contact is the last clinic visit date or the last discharge date, or whatever the latest date is.

b. If you are aware of a more recent date the patient was last alive after discharge (such as through correspondence or telephone contact), record the latest date of contact known. The date may be the date the patient was contacted by telephone or responded to a letter. Record the date of the actual patient contact. Do not use the date information was received in the mail, or the date information was requested from a patient, physician, or clinic. Do not record the date follow-up information was recorded on the abstract or follow-up card, or the date the case was entered into the computer.
Note: Failure to find a patient on a list of deceased individuals does not constitute evidence that the patient is alive. Neither *Vital Status* nor *Date of Last Contact or Death* should be changed.

c. If a patient has multiple primaries, all records should have the same date of last contact. If the State Cancer Registry receives information from more than one facility for the same patient, this field will be updated in each of the patient's records. The latest date of last contact or death will be recorded for all of the patient's tumors.

d. Estimate the date of last contact when the exact date is not available. An approximate date is better than using unknowns.

   If the specific day of the month is unknown, leave the day section blank

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

DESCRIPTIVE TERM USED	DATE CODE
Spring	April
The middle of the year	July
Fall	October
Winter	Try to determine if this means the beginning of the year (January) or the end of the year (December). Code as indicated.

The *Vital Status* and *Cancer Status* fields below relate to this date.

DATE OF LAST CONTACT FLAG

Item Length: 2
Data Type: Numeric
ACoS: Required
NAACCR Item #1751
State Registry: Required

*Required if applicable for cases diagnosed 01/01/2015-12/31/2022

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of Last Contact* (NAACCR Item #1750). This data item was added to Volume II Version 12 (effective January 2010).

Rationale
Prior to version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes
12 A valid date is applicable but not known. (The date of last contact or death is unknown).
Blank A valid date is coded in the *Date of Last Contact or Death* item.

Instructions
a. Leave this item blank if *Date of Last Contact or Death* has a full or partial date recorded.
b. Use code 12 if the *Date of Last Contact or Death* cannot be determined.
c. Code this data item (when appropriate) even if your software uses the traditional format for date entry.

Examples:

Description	Date (Leave unknown portions blank.)	Date of Last Contact Flag
Full date known	*01/08/2021 or 2021/01/08	Blank
Month & year known	*01/_ _/2021 or 2021/01/_ _	Blank
Year only known	*_ _/_ _/2021 or 2021/_ _/_ _	Blank
Unknown date	*_ _/_ _/_ _ _ _ or _ _ _ _/_ _/_ _	12

***** For date entry, your software may use the traditional format (MMDDCCYY) or the interoperable format (CCYYMMDD). The WEBPLUS program uses the traditional format. The computer will store either in the interoperable format.

VITAL STATUS
(STATUS OF PATIENT)

NAACCR Item #1760

Item Length: 1
Data Type: Numeric
ACoS: Required
State Registry: Required

Description
This is a required 1-character field to record a code that indicates patient's vital status (dead or alive) as of the *Date of Last Contact (or Death)*. Use the most accurate information available.

Codes
0 Dead
1 Alive

Instructions
a. If no follow-up information is ever received, code the patient's vital status on the date of his/her last discharge from the hospital.

b. If a patient has multiple primaries, all records should have the same patient vital status. Do not change a patient's vital status at discharge unless new follow-up information is available.

c. There is no code for "unknown," since you must know at least whether the patient was alive or dead at the time he or she last left your facility.

Note: Failure to find a patient on a list of deceased individuals does not constitute evidence that the patient is alive. Neither *Vital Status* nor *Date of Last Contact or Death* should be changed.

CANCER STATUS
(STATUS OF TUMOR)

NAACCR Item #1770

Item Length: 1
Data Type: Numeric
ACoS: Required
State Registry: Required

Description
This is a required 1-character field to record a code that indicates the presence or absence of clinical evidence of the patient's malignant of non-malignant tumor as of the *Date of Last Contact (or Death)*. Tumor status changes if the patient has a recurrence or relapse.

Codes
1 No evidence of this tumor
2 Evidence of this tumor
9 Unknown, indeterminate whether this tumor is present, not stated in the patient record

Instructions
a. Code the best available information concerning the tumor status of the patient as of the date of last contact or death.

b. Code tumor status independently for each primary tumor. If a patient has multiple primaries, each record could have a different tumor status. If the patient has evidence of the other primary tumor, but does not have evidence of this tumor, code 1, no evidence of this tumor.

c. Code patients who have hematopoietic disease (e.g., leukemia) that is in remission as no evidence of this tumor (code 1).

d. Official death certificates do not always record the presence of tumors. If the registry abstract indicates that the patient had a malignant or non-malignant tumor immediately before death, code evidence of this tumor (code 2). Consult the registry physician advisor when questions arise. Decisions on tumor status coding can be based on information such as:

- How much time elapsed between the last follow-up and patient's death?
- Was the last follow-up and tumor status information from a medical source (physician, hospital admission)?
- Are autopsy findings available to the registry?

Example: A prostate cancer patient has a two-year history of metastatic disease. The patient had a bone scan at your facility in April 2021. The urologist's diagnosis was progressive bony metastases and the bone scan confirmed extensive bone destruction. The registrar finds an obituary documenting the patient's death in a nursing home in June 2021. Record the tumor status as "evidence of this tumor" (code 2).

FOLLOW-UP SOURCE

NAACCR Item #1790

Item Length: 1
Data Type: Numeric
ACoS: Required
State Registry: Required if available*

*Required if available for cases diagnosed 01/01/2008 and later.

Description
This item records the source from which the latest follow-up information was obtained.

Rationale
This data item is used by registries to identify the most recent follow-up source.

Codes

Code	Label	Definition
0	Reported hospitalization	Hospital at another institution/hospital or first admission to the reporting facility.
1	Readmission	Hospitalization or outpatient visit at the reporting facility.
2	Physician	Information from a physician.
3	Patient	Direct contact with the patient.
4	Department of Motor Vehicles	The Department of Motor Vehicles confirmed the patient has a current license.
5	Medicare/Medicaid file	The Medicare or Medicaid office confirmed the patient is alive.
7	Death certificate	Information from the death certificate only.
8	Other	Friends, relatives, employers, other registries, or any sources not covered by other codes.
9	Unknown/ not stated in patient record.	The follow-up source is unknown or not stated in the patient record.

CAUSE OF DEATH

Item Length: 4
Data Type: Alphanumeric
Left Justified
ACoS: N/A
State Registry: Required

NAACCR Item #1910

Description
This is a required 4-character field in the WEBPLUS abstract screen to record the *ICD-10* (*International Statistical Classification of Diseases and Related Health Problems,* Tenth Revision) code for the underlying cause of death. Record the cause of death listed on the death certificate. Central (state) registries are the primary users of this data item. Use the underlying cause of death (*ICD-10* code), even if believed to be in error. All underlying causes of death should be left-justified. The decimal point is assumed to be between the third and fourth digit, but should not be entered.

Special Codes
0000 Patient alive at last follow-up
7777 State death certificate or listing not available
7797 State death certificate or listing available, but underlying cause of death not coded; or the coded underlying cause of death is not available

Instructions
a. For all cases not meeting one of the above code descriptions and where the patient has died and the cause of death is known, record the *ICD-10* underlying cause of death code.

b. Use code 7777 when the patient has died, but the death certificate is not available. Hospitals would almost always record code 7777 for cause of death.

c. Use code 7797 when the patient has died, but the coded underlying cause of death is not available.

d. Some codes have an optional fifth digit. The fifth digit is not used in coding cause of death.

e. The *ICD-10-CM* code for cause of death obtained from the medical record should not be used for the underlying cause of death code if no death certificate is available. Use only the *ICD-10* code from the death certificate. If hospitals record cause of death from the medical record for their own use, the State Registry will replace it with the death certificate code.

f. *Examples:*

Underlying Cause of Death	ICD-10
Cancer of the thyroid	C73
Acute appendicitis with peritonitis	K35.0
Adenocarcinoma of stomach	C16.9

PLACE OF DEATH - STATE

Item Length: 2
ACoS: N/A
State Registry: Required if available

NAACCR Item #1942

Description
This is a 2-character field for recording the state or province where the patient died. The State Registry requires the item if the information is available.

Codes
See the table provided for *State at Diagnosis* for the list of state codes.

Special Codes
XX Died in a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is known (code the country in *Birthplace-Country)*
YY Died in a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is unknown
US Died in the U.S. (including its territories, commonwealths, or possessions) and the state is unknown
CD Died in Canada and the province is unknown.
ZZ State where patient died is unknown

Note
This item was first defined for use in 2013. Cases diagnosed before 2013 should be converted automatically by the registry's software from the former *Place of Death*.

PLACE OF DEATH - COUNTRY

Item Length: 3
ACoS: N/A
State Registry: Required if available

NAACCR Item #1944

Description
This is a 3-character field for recording the country where the patient died. The State Registry requires the item if the information is available.

Codes
For country codes, see one of the following:

- *The SEER Program Coding and Staging Manual*, Appendix B at http://seer.cancer.gov/tools/codingmanuals/
- *STORE Appendix C at https://www.facs.org/qualityprograms/cancer/ncdb/registrymanuals/cocmanuals*

Examples
USA United States

CAN Canada
ZZX Non-US NOS
ZZU Place of death is unknown

Note
This item was first defined for use in 2013. Cases diagnosed before 2013 should be converted automatically by the registry's software from the former *Place of Death*.

REMARKS

NAACCR Item #2680

Data Type: Text
ACoS: N/A
State Registry: Optional

Description
This is an optional text field in the paper and WEBPLUS abstracts for recording information not elsewhere provided for or for overflow from other text fields. Facilities using other types of registry software should follow their vendor's instructions for recording text. *ISCR will no longer accept paper abstracts beginning 1/1/2026

Rationale
Text is needed to justify the codes selected for the data items and to record information that is not coded at all. The text is used for quality control and special studies.

Instructions
The following kinds of information may be recorded in this field:

a. History of symptoms

b. Clinical findings

Example 1: Mass noted in right (rt.) breast 2 months ago; mammogram prior to admission (PTA) suspicious. Physical exam (PE) revealed 2 cm. mass in the upper outer quadrant (UOQ) of the right breast. No axillary lymphadenopathy noted.

Example 2: Pleural effusion or ascites, weight loss, etc.

c. Diagnostic and metastatic work-up (type of procedures, dates, and results)

(1) Record only work-up related to the malignancy and the spread of the disease.

(2) When recording test results, include the interpretation (positive, negative, elevated, within normal limits) with the value because the definition or parameters for "normal" values may differ from one facility to another.

d. Overflow from other text fields if additional space is needed.

CENTRAL TUMOR REGISTRY NUMBER **(FOR STATE USE ONLY)**
Item Length: 6 + 2
Data Type: Numeric

Leave this item blank.
NAACCR Item #20

Description
This is an 8-character field (when combined with sequence number). The Central Tumor Registry (CTR) Number is an internal number that will be assigned and used by the State Cancer Registry only. In the WEBPLUS program, it appears in the abstract screen and on reports as CTR # (Central Tumor Registry Number). There is a unique CTR number for each person in the central registry. If a person has more than one primary tumor, the sequence number will distinguish one tumor from the next.

In hospitals using the WEBPLUS program, the CTR number that appears in the hospital's abstract screen is the same as the hospital registry's accession number for the patient. The first four digits are the accession year (YYYY). The next five digits are the accession number (#####). The last two digits are the sequence number (SQ), so that the number looks like this: YYYY#####SQ.

When the hospital submits cases on diskette to the State Registry, the CTR number is automatically changed to the unique CTR number used by the central registry. Hospital accession numbers are also maintained in the central registry.

DATE CASE REPORT RECEIVED (STAMP DATE) **(FOR STATE USE ONLY)**
NAACCR Item #2111

Item Length: 8
Data Type: Numeric

Description
This is an 8-character field for the date the electronic or paper abstract (or source record) is received by the State Cancer Registry for the respective tumor. If multiple reports are received from two or more sources, the applicable date for each reporting source is maintained in the State record for the tumor. The item label is *Stamp Date* in the State WEBPLUS screens. WEBPLUS screens for hospitals do not include this item. *ISCR will no longer accept paper abstracts beginning 1/1/2026

Rationale
This item is used to assess and monitor the timeliness of reporting. Timeliness of abstracting (and reporting) is a concern for all standard-setting organizations and consequently, timeliness standards have been established. This item can be used with the *Date of First Contact* to measure timeliness of reporting by individual facilities to the State Registry.

CHAPTER 6: CORRECTIONS AND FOLLOW-UP

OVERVIEW

This chapter describes how corrections, deletions, and follow-up information on previously submitted cases are reported to the State Cancer Registry. Part I explains the purpose for corrections and follow-up; who submits reports; and when, how, and where reports are submitted. Part II describes various methods to accomplish follow-up. Part III details how to complete the Correction and Follow-up Form. Part IV explains how to complete the Correction form for Multiple Patients. Forms are available upon request from the State Cancer Registry.

PART I: GENERAL INSTRUCTIONS

A. Purpose

1. Corrections
   The latest or most complete information and conclusions about a case should be reported. Over time, documentation may be added to a patient's medical record that was not available when an abstract was originally completed. Such information may, in the interest of accuracy, require modification of the originally reported data. For example, early diagnostic information may support a diagnosis of metastatic lung cancer. Later it may be learned that the original site of disease was breast cancer. In another case, more extensive work-up may reveal that disease originally thought to be malignant is benign and the case should be deleted from the State Cancer Registry database. For such cases it is important to correct the primary site, histology, and/or extent of disease as information becomes more complete. There is no time limit for making revisions that give better information about the **original** diagnosis or stage.

   Note: This does not mean that as the disease progresses, the stage should be changed according to the latest stage of disease. Staging should reflect only information available through completion of surgery(ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer.

2. Follow-Up
   Systematic, annual follow-up of cancer patients is an important function of the cancer registry. Annual follow-up achieves two important objectives:
   - To encourage continued medical surveillance of patients for early detection and treatment of recurrences and subsequent cancer;
   - To obtain information for patient care studies and survival.

   Additional benefits of hospital-based follow-up efforts include provision of follow-up service to physicians and enhanced public relations resulting from the hospital's continued concern for patient welfare.

   From an epidemiologic perspective, a statewide follow-up effort permits tracking of patients in the event that case control studies are required or patient contact is necessary to assess public health risks.

   The American College of Surgeons, Commission on Cancer requires a specified successful follow-up rate for all cancer programs seeking approval.

B. Who Submits Correction and Follow-Up Reports

Any hospital having correction or follow-up information about a patient who was previously reported to the State Cancer Registry may submit information on that patient to the State Cancer Registry.

C. When to Submit Corrections and Follow-Up Information

1. Corrections
   Corrections or modifications to previously submitted data should be completed and submitted to the State Cancer Registry as soon as possible after the need for correction is discovered.

2. Follow-Up
   Follow-up should be performed at least annually for each patient, usually on the anniversary of the date of last contact.

   Follow-up reports may be submitted to the State Registry at least quarterly, particularly for hospitals that treat a large number of cancer patients. Hospitals are encouraged to submit updated information more frequently in order to maintain a complete record of the patient's treatment and a current database for analytic purposes. This permits an orderly workflow at both the State Cancer Registry and the reporting hospital.

D. How to Report Corrections and Follow-Up Information

Corrections, deletions, and follow-up can be submitted in a number of different ways that are outlined below.

1. Copies of the Original Paper Abstract ***ISCR will no longer accept paper abstracts beginning 1/1/2026**
   If your hospital reports by paper abstract, changes or follow-up may be submitted on a copy of the original paper abstract.
   a. Make a copy of the original form.
   b. In red, write "Correction," "Delete," or "Follow-Up" at the top of the form.
   c. In red, cross out the original data in the field to be corrected and write the corrected or follow-up information beside the old.

2. Correction and Follow-Up Form
   Changes and/or follow-up may be submitted on a "Correction and Follow-Up Form," explained in Part III of this chapter.
   a. Complete all identifying information on the form to ensure the appropriate case is corrected, deleted, or updated.
   b. Complete section D. "Corrections" or section F. "Follow-Up Information," as applicable.
   c. Make a legible copy of the original form and mail the copy to the State Cancer Registry, keeping the original at your hospital.

3. Corrections for Multiple Patients
   Corrections for multiple patients, such as those identified on a discrepancy report from the State Cancer Registry, may be submitted by one of the following two methods:
   a. Write the correct information next to the error message on the discrepancy report and return the corrected report to the State Registry; or
   b. Record the corrections on the "Correction Form for Multiple Patients" explained in Part IV of this chapter.

4. Corrections by Telephone
   Changes may be submitted by calling the State Cancer Registry at (317) 233-7158 with the correction or deletion. Changes of this type should be limited to five patients or less. Be prepared to identify the case by patient name, sequence number, and possibly date of birth or Social Security Number so that State Registry staff can change the correct record.

5. Computerized Registries
   Follow-Up and Recurrence
   When the State Registry processes disks received from hospitals with computerized registries, the most current follow-up information is automatically entered into the computer from the diskettes. This includes date of last contact or death, patient's vital status, and cause of death, if applicable.

Other Changes (Corrections or Deletions)
All other information the hospital may have changed, updated, or corrected in any previously reported case is NOT automatically updated in the computer when the disks are processed. **These changes must be reported manually, in writing, or verbally.**

The information will not be automatically updated in order to prevent writing over data that had been previously corrected or consolidated by State Registry staff. The system at the State Registry is designed so that when reports for a single case are received from multiple hospitals and there are significant differences in the information reported, they are not permitted to write over each other or merge until State Registry staff have analyzed and researched the differences and determined the best information and/or codes. The cases are then manually changed and consolidated. The work of the State Registry staff would be lost if new information from one of the hospitals could write over any changes made in the consolidation process. The consolidation process is described in more detail in Chapter 7 of this manual.

E. Where to Send Correction and Follow-Up Reports

Envelopes should be carefully sealed and labeled "CONFIDENTIAL MEDICAL INFORMATION." The envelope should be clearly addressed:

Indiana State Cancer Registry
Indiana Department of Health
2 North Meridian Street, Section 6-B
Indianapolis, IN 46204-3010

All reports submitted must be legible. Illegible forms will be returned to the hospital.

The hospital should keep a record of reports submitted to the State. Cancer Registry personnel will keep track of reports received from each hospital.

Corrections may be uploaded through the WebPlus secure server through the "file upload" feature. Contact ISCR for instructions.

F. Confidentiality

As correction and follow-up reports are being completed, care should be taken to ensure that the content of each is treated with the same level of security and confidentiality as the medical record. These reports are abbreviated medical records and should be treated as such. A full discussion of confidentiality is found in Chapter 8 of this manual.

PART II. FOLLOW-UP

Reporting annual follow-up data to the State Cancer Registry is optional. The State encourages hospitals to report follow-up information whenever possible in order to obtain a more complete record. Accurate and complete information about the current health of each patient may be difficult to obtain, but the importance of collecting this information is undeniable.

A. Frequency of Follow-Up

Follow-up efforts should be initiated on those patients for whom no information has been received within the last 12 months. Cases are considered delinquent if no contact has been made within 15 months after the date of last contact. A follow-up (tickler) file must be maintained, either manually or by computer, by which to identify patients due for follow-up. For hospitals that submit follow-up information, it is recommended that follow-up data collection be a monthly task of the hospital that first treats a case.

B. Cases to Include in Follow-Up

The American College of Surgeons, Commission on Cancer, requires annual follow-up on all analytic cases.

A hospital may elect to report recurrence or follow-up information on any case that has been reported to the State Cancer Registry. See Chapter 3 on Reporting for further information on the reportable cases.

Patient of advanced age and stage of disease should not be assumed deceased and withdrawn from follow-up after a prescribed time period. These patients may have exceptional responses and occasionally be long-term survivors.

C. Cases Not to Include in Follow-Up

- Carcinoma in situ of the cervix
- Non-analytic cases (cases neither diagnosed nor receiving any part of the first course of therapy at the reporting hospital, *Example:* class 30+)
- Patients residing in foreign countries
- Cases that were not required to be reported to the State Cancer Registry (see Chapter 3, Section D of this manual.)

D. Data Fields to Include in Follow-Up

The State Cancer Registry needs minimal follow-up data on patients in its database in order to calculate survival time from date of cancer diagnosis to date of death. This data includes:

- Date of last contact or death
- Patient's vital status (alive or dead)
- Cancer status (with or without disease)

A full explanation of these items is found in Chapter 5 of this manual.

There are additional data items relating to recurrences and follow-up that hospitals may want to collect for their registries: date and type of first recurrence, distant site(s) of first recurrence, and subsequent treatment for persistent or recurrent disease. Since the State Registry does not collect these items, they will not be explained here. Please refer to the *Standards for Oncology Registry Entry (STORE)* for coding rules and information.

E. Follow-Up Sources

1. Most follow-up information is obtained through review of hospital readmissions, outpatient visits, or letters to the patient's physician. Hospitals are encouraged to share follow-up information with other facilities that are following the same patient. Remember to re-contact physicians even though the first contact may not have been productive. After a period of time, the patient may have returned for a subsequent visit to the physician. When these methods are not effective in providing follow-up information, a variety of other sources may be employed.

2. Hospital policy, consistent with legal requirements for confidentiality, should be developed governing potential contact with relatives, friends, etc. If hospital policy permits, patients may be contacted by letter or telephone. All patient contact should be accomplished in a responsible and compassionate manner. Many hospitals' policies caution against mention of the patient's diagnosis.

3. Voter Registration roles can be a source of addresses for patients who have moved. Date of the last election in which the patient voted or date of registration to vote may be used as the date of last contact if no further information can be obtained.

4. Miscellaneous methods of locating patients include the Social Security Administration office, medical and life insurance companies, local utility companies, and credit bureaus. Most of these sources will provide only last known address.

5. More information on follow-up techniques can be obtained through the American College of Surgeons.

PART III: INSTRUCTIONS FOR COMPLETING CORRECTION AND FOLLOW-UP FORM

The number in front of the title of each item described below corresponds to the number on the Correction and Follow-Up Form for that data field. Shaded fields indicate items which are optionally reportable: completion is desirable, but not required. It is important to enter all information accurately and legibly.

A. Purpose of Form

Check the box which describes your purpose for completing the Correction and Follow-Up Form.

1. Correction
   Check the "Correction" box if you are modifying or correcting a record you have previously submitted to the State Cancer Registry.

2. Follow-Up
   Check the "Follow-Up" box if you are reporting follow-up information.

3. Delete Case
   Check the "Delete Case" box if you want the State Cancer Registry to delete a record previously submitted. This might be used if, after reporting a case to the State Cancer Registry, you obtained additional information and concluded the case was non-reportable. Record the reason the case should be deleted in the "Remarks" section of the form.

B. Patient Identification

The information in Items 4 through 6 should match the information previously submitted for the patient. It will be used to identify the record that requires the change or follow-up being reported.

4. Patient Name
   Enter the patient's last name, first name, and middle initial according to instructions in Chapter 5.

5. Social Security Number
   Enter the patient's Social Security Number according to instructions in Chapter 5.

6. Date of Birth
   Enter the patient's birth date according to instructions in Chapter 5.

7. State CTR #, if known
   This is a unique 10-digit number assigned to every patient in the State Registry. Additional information on the CTR number can be found in Chapter 5.

   If you have a report from the State Registry that lists the Central Tumor Registry (CTR) number, enter it in Item 7. The CTR number appears in the first column of Discrepancy Reports from the State Registry. After the 10-digit CTR number, a dash follows, and then the 2-digit sequence number, which should be recorded in Item 10 on the Correction and Follow-Up Form.

   Leave the item blank if the CTR number is unknown or unavailable.

C. Hospital and Tumor Identification

8. Hospital Identification Number
   Enter the 3-digit hospital ID number according to instructions in Chapter 5,

9. Hospital Accession Number
   Enter the 9-digit hospital Accession Number according to instructions in Chapter 5.

10. Sequence Number
    Enter the 2-digit Sequence Number according to instructions in Chapter 5.

11. Original Primary Site

Enter the *ICD-O-3* primary site code number as originally submitted to the State Registry according to instructions in Chapter 5. If primary site is the item you want to correct or change, the corrected code will be reflected in Item 14 where corrections are described.

D. Corrections

12. Item Name
Enter the name of the item (field) you want to correct or change. For example, if you are changing the primary site code, enter "Primary Site."

13. Change From
Enter the information that was originally submitted for the field you are correcting. If you are changing the Summary Stage from "localized" to "in situ," for example, enter the code you originally submitted (1). Enter the code first, and the description if space allows. For example, enter 1 – localized.

14. Change To
Enter the new information for the field you are correcting. If you are changing the Summary Stage from "localized" to "in situ," for example, enter the code you want to change the Summary Stage to (0). Enter the code first, and the description if space allows. For example, enter 0 – in situ.

E. Remarks

The "Remarks" field is to be used to record any information that may be helpful to you or State Cancer Registry staff who will be entering the data. The type of information that might be recorded here includes an explanation of the correction if it is anything other than routine. If a case is being deleted, record the reason in this field.

F. Follow-Up Information

The "Follow-Up Information" fields allow for submission of up to three years of follow-up information. The hospital should keep the original abstract and send a copy to the State Registry. Additional years of follow-up can then be added to the original Correction and Follow-Up form, with a copy being sent to the State every year.

After each 12-month follow-up contact is made, complete the next follow-up information section.

15. Date of Last Contact
Enter the date of the most recent patient contact or the patient's date of death. Complete this section according to instructions in Chapter 5.

16. Vital Status (Patient Status)
Enter the patient's vital status (alive or dead) as of the last date of contact. Complete this section according to instructions in Chapter 5.

17. Cancer Status
Enter the patient's cancer status (with or without evidence of cancer) for this primary as of the last date of contact or death using the best available information. Complete this section according to instructions in Chapter 5.

18. Cause of Death
Enter the ICD-10 underlying cause of death code listed on the death certificate. Complete this section according to instructions in Chapter 5.

Special Codes
0000 Patient alive at last follow-up
7777 State death certificate or listing is not available
7797 State death certificate or listing is available, but the underlying cause of death is not coded or the coded underlying cause of death is not available

19. Submitted By
    Enter the name or initials of the person completing the Correction and Follow-Up Form. The name or initials may be legible printed, written, or typed. The signature of the preparer is not required. This information is collected in case the State needs to contact the preparer for questions.

20. Date Completed
    Enter the date the form was completed. The date may be legibly printed, written, or typed.

PART IV: INSTRUCTIONS FOR COMPLETING CORRECTION FORM FOR MULTIPLE PATIENTS

The "Correction Form for Multiple Patients" can be used to report corrections for up to four different patients. The form can be used to address questions identified on the State Registry's discrepancy lists or to report any corrections on multiple patients.

A. Hospital Identification

1. Enter the name of your hospital. If there is more than one hospital with the same name (e.g., there are six St. Joseph hospitals in Indiana), add the city name or an abbreviation of the city.

2. Enter the 3-digit hospital identification number according to instructions in Chapter 5.

B. Corrections

1. Enter the patient's last and first names in the space under the item title Name according to instructions in Chapter 5.

2. Enter the Central Tumor Registry (CTR) number, if known, as it appears in the first column of the Discrepancy Report. The first 10 digits are the CTR number, followed by a dash, and then the 2-digit Sequence Number (e.g., 0000123456-00). Additional information on the CTR and Sequence Numbers can be found in Chapter 5.

3. Enter your hospital's Accession Number, according to instructions in Chapter 5. The first 4 digits are the year the patient was first accessioned, followed by a dash, and then the five digit Accession Number.

4. On lines 1-5, record an explanation of the change(s) being reported. The change(s) should be recorded as described for the "Correction and Follow-Up Form." If the correction involves a change of codes, record both the old and the new codes.

C. Submitted By and Date

Enter the name or initials of the person completing the form on this line. The name or initials may be legibly printed, written, or typed. The signature of the preparer is not required. This information is collected in case State Registry staff need to contact the preparer for questions.

Enter the date the form was completed. The date may be legibly printed, written, or typed.

CHAPTER 7: QUALITY CONTROL

A. OVERVIEW

Definition
Quality control is the cancer registry function concerned with the assessment and improvement of data quality. The characteristics of quality include case completeness, data accuracy, data completeness, and timeliness.

Goals
- To detect and correct errors or omissions in existing data;
- To identify and effectively address opportunities for improvement in training, documentation, and/or systems in order to assure the quality of subsequent data collection.

Responsibility
A designated CTR (Certified Tumor Registrar) is responsible for the quality assurance program. Qualified, experienced CTRs conduct quality assurance activities.

Components of Quality Control
The State Registry quality control activities include the following:

- Analysis of observed/expected completeness rates
- Casefinding audits
- Reabstracting and re-coding audits
- Visual editing of data quality
- Computer editing of data quality
- Evaluation and consolidation of case-sharing and duplicates
- Procedure manual (documentation) maintenance
- Staff training and development
- Feedback and consultation from quality control activities to data collectors
- Resolution of discrepancies

B. ASSESSMENT/IMPROVEMENT OF DATA ACCURACY AND COMPLETENESS

1. Observed/Expected Completeness Rates

Case Volume
Case volume is monitored to assess and improve the completeness of data. The actual number of cases reported by each facility is compared to an estimated expected volume. The expected case volume for a year is based on an assessment of the number of cases reported in each of the preceding five years. An annual caseload can be estimated by the number of acute care medical and surgical beds at the facility. A hospital with 250 acute medical and surgical beds may typically see 250 new cancer cases per year. For small hospitals without radiation therapy centers, this figure is probably within 20% of the actual caseload for the first years of the registry. For hospitals offering radiation therapy, 50% is added to the total number of beds to determine annual caseload (e.g., a hospital with 100 beds would see 150 cancer cases per year). This formula is not reliable for major referral centers.

When fewer reports are received than expected for a given year, the reporting source is contacted to assess the reason. If the decline in number of cases is not the result of an explainable cause, such as a change in facility services or an abstracting backlog, the facility will be asked to review casefinding procedures. The Indiana State Cancer Registry personnel will be available for consultation and assistance in the review. A review would include an examination of the hospital's patient index; pathology reports; chemotherapy, radiation therapy, and outpatient logs; diagnostic or disease index; and print-outs of cancer-related diagnostic codes from the billing system.

Patterns

Indiana data is compared with national averages in order to assess and improve the completeness of data. Based on data from the *Surveillance, Epidemiology, and End Results (SEER)* Program of the National Cancer Institute, the proportion of cases from each of the common organ sites is compared to Indiana data and used to determine whether Indiana data are comparable to national data. Any discrepancies will be investigated.

2. Casefinding Audits

Casefinding audits are performed to assess and improve the completeness of reporting. The audit is a study to verify that a facility is reporting all applicable newly diagnosed cancer cases and to help the facility improve casefinding procedures if needed. The audit involves reviewing the facility's casefinding procedures and all sources for potential cases in the facility. The cases identified in this review are compared with cases reported and missed cases are documented. The reviewer calculates a completeness rate from these numbers and compares the rate with the completeness rate goal of 95%. Separate procedures are available describing in more detail how casefinding audits are conducted.

Each year the State Registry will select up to 20% of Indiana hospitals for casefinding audits. Sample specifications will be based on hospital annual caseload. Six months will be reviewed for hospitals with 0-100 annual cases. Three months will be reviewed for hospitals with 101-499 annual cases. One month will be reviewed for hospitals with 500 or more annual cases.

The State Registry will make consultative recommendations to the hospital registrar during the audit and will submit a written report of results and recommendations to the hospital and the State Registry within thirty days of the audit.

3. Reabstracting Audits

Reabstracting audits are performed to assess and improve data accuracy in terms of the data collectors' adherence to established principles of coding, abstracting, and staging. The audit involves reviewing the facility's source records for randomly selected cases and reabstracting selected data elements. The reabstracted items are compared with the facility's abstract and discrepancies are reviewed to identify needs for clarification, corrections, and education. Separate procedures are available describing in more detail how reabstracting audits are conducted.

Each year the State Registry will select up to twelve (10%) Indiana hospitals for reabstracting audits. The sample will be limited to a subset of cases diagnosed the previous year in the same half of the year as the time of the audit.

The State Registry staff will make consultative recommendations to the hospital registrar at the time of the audit and will submit a written report of results and recommendations to the hospital and the State Registry within thirty days of the audit.

4. Recoding Audits

Recoding audits may be performed to assess and improve the accuracy of data from new coders or from coders with educational needs identified by other quality control activities. The audits involve independently reassigning codes to abstracted text information or from copies of specific medical record documentation requested from the facility. The recoded items are compared with the original codes submitted and discrepancies are analyzed to identify needs for clarification, correction, and education.

The State Registry staff will submit a written report of results and recommendations to the hospital and the State Registry within thirty days of the audit.

5. Consolidation Audits

Audits of a sample of consolidated cases are performed to assess whether the "best" value for each of a specified set of variables is coded in the final (summary) consolidated cases. All source records are reviewed in the audit process.

6. Quality Control for Newly Submitted Cases

Each new submission of cases is loaded into a subsystem and subjected to both visual and computer edits before being transferred into the main database.

a. Visual Edits

Visual editing is performed to assess and improve data accuracy and completeness. Visual reviews are performed on cases received by State Cancer Registry staff to determine if data are complete, as well as, logical and internally consistent. Visual editing includes assessment of frequency reports of required items for blank items or invalid codes. It may involve analysis of listings with specified data items for all cases in a subsystem. It may involve one hundred per cent review of each abstract when the cases involve difficult diagnoses, are from new coders, or are from coders with educational needs identified by other quality control activities.

- Dates of birth, accession years, admission and discharge, initial diagnosis, and treatment are monitored for logical progression.
- Accession number, sequence number, and class of case are visually reviewed for logic.
- Agreement with laterality, site codes, histology, and sex are reviewed for logical consistency.
- Completeness is assessed by monitoring the number of “unknowns” or blanks in demographic and cancer data.

The reporting source is contacted as needed for correction, clarification, or completion of required data elements.

Transcription accuracy reflects the quality of procedures for transferring the data from the paper abstract to electronic medium. For cases entered from paper abstracts by State Cancer Registry personnel, each screen is carefully checked against the abstract for transcription errors prior to transfer to the main database.

b. Computer Edits

The State Cancer Registry develops and applies State-required computerized edit sets based on those from the NAACCR standard edits that are required by NPCR. These edits are provided to WEBPLUS hospitals; are available to facilities using other registry systems as part of the FTP submission procedure; and are made available to other vendors for incorporation into their registry systems.

The computerized edit sets assess the accuracy of all data received by applying standard computerized data edits. The computerized edits include the following: single field (to check for valid codes), multi-field (to check for consistency and logic between different fields), multi-record (to check for consistency between multiple sequences), and multi-database (to check for consistency between different hospitals seeing the same patient for the same tumor). Inconsistencies or discrepancies not detected during manual edit checks are identified by these edits.

State Registry staff members analyze the edit reports and the abstracts and make corrections as indicated. When the staff member determines that the original information is correct, the edit is overridden and the reason is recorded in the “Comments” section.

When the analysis of computerized edits identifies variations from coding rules or incomplete information, the issues are reported to the responsible facility for correction, clarification, or completion of required data elements. Responses from the reporting source with justification and/or documentation supporting the original information are reviewed and changes made as indicated.

Quality control reviews are performed on reports before the data are released. In addition to the routine computerized edit checks, the subset of cases used in the report is checked for duplicate cases to ensure patients are not counted more than once for each tumor. Patterns in the data are studied for inconsistencies. For example, a listing of pediatric cases containing colon, breast, or prostate cancers would identify a need for further review and action

7. Consolidation

The State Cancer Registry may receive duplicate reports for a single case from the same hospital, multiple hospitals, nonhospital facilities, death records, or another state registry. State Cancer Registry staff identify duplicate reports for a single case, resolve any discrepancies between reports, and consolidate the reports into a single record. Applicable multiple primary rules of the standard-setting organizations are applied. The purpose of consolidation procedures is to accurately determine cancer incidence in Indiana.

Identification of Duplicate Cases

The process of identifying duplicate reports (that have been submitted electronically) is initiated when recently received cases are transferred into the main database. See Attachment B, Procedure for Transferring Subsystems to the Main Database. The following mechanisms are used to identify potential duplicates: computer-automated merges, computer-generated identification of potential duplicates (error reports), manual search of the database by Social Security Number, and periodic execution of computerized multiple sequence consistency checking.

Computer-automated Merges

When critical identifying data elements are identical (e.g., patient name, Social Security Number, date of birth, sex, sequence number, primary site code), the oncoming case merges with the duplicate case in the main database. A list of all such merges is generated by the system and printed by staff for analysis described in the Analysis of Discrepancies section below.

Error and Possible Match Reports

When some, but not all, critical, identifying data elements are identical, the oncoming case is added as a new case into the main database. The system identifies most of these cases on either the Error Report or the Possible Match Report. The Error Report lists the cases that match all critical elements except the primary site and identifies each new case by the original case's Central Tumor Registry (CTR) number and a sequence in the 90's. The Possible Match Report lists the cases that match all critical elements except the sex, date of birth, or Social Security Number and identifies each new case by a newly assigned CTR number with the sequence as reported. The reports are printed by staff for analysis described in the Analysis of Discrepancies section below.

Note: The system does not identify possible matches that differ only in sequence, last name, or some variations in first name (e.g., Theodore versus Ted). Most of these are identified by Multiple Sequence Report analysis or the Social Security Number search procedure.

Social Security Number Search

After resolution of potential duplicates identified by the Error and Possible Match Reports, staff search the main database by the Social Security Numbers of all the oncoming cases, identifying additional potential duplicates for analysis described in the Analysis of Discrepancies section below.

Computerized Multiple Sequence Consistency Checking
The system's Multiple Sequence Consistency Checking identifies discrepancies between legitimate multiple primary cases, as well as potential duplicate cases that may not have been resolved in the procedures described above. This program is executed periodically and all discrepancies and potential duplicates are analyzed and resolved.

The process of identifying duplicate reports (that have been submitted in other than electronic format) is initiated by manually searching the main database and subsystems. Matched records for the same patient are compared, using applicable multiple primary rules to determine whether the same primary is involved. If the reports are determined to be for the same primary, the analysis of discrepancies process described below is applied.

Analysis of Discrepancies
The abstracts for each of the potentially duplicate cases are opened and reviewed side by side so that all data items are compared and any discrepancies identified. For cases that were automatically merged, the original abstract for oncoming case is available as the "pristine" record, which can be opened and compared with the existing abstract.

Discrepancies between patient identifying data items may be resolved by searching the Social Security Death Index, if applicable. The reporting facilities may also be contacted for review of their source records for the correct information. If the analysis results in a determination that the cases are duplicate cases, the abstract that will be the consolidated record (the case with the earlier date-on-file) is corrected as applicable.

Discrepancies between cancer identifying data items and treatment data are reviewed with analysis of supporting text; assessment of the more extensive diagnostic work-up; consideration of class of case and dates seen; and appropriate application of coding rules. The more accurate and complete information is identified. The reporting facilities may also be contacted for review of their source records for clarification. If the analysis results in a determination that the cases are duplicate cases, the abstract that will be the consolidated record (the case with the earlier date-on-file) is corrected as applicable.

If the analysis results in a determination that the reports are duplicate cases that have not been automatically merged, they are manually merged. The oncoming case is merged to the case with the earlier date-on-file (the consolidated case) by deleting the oncoming case and entering the consolidated case CTR number and sequence in the box provided by the system. The consolidated records for all merged cases retain the facility-specific information (accession number, sequence, admission and discharge dates, medical record number, and class of case) for up to ten facilities. In addition, the original abstract submitted by each facility is retained as a "pristine" record.

If the analysis results in a determination that the cases are separate primaries (same patient), both reports are saved. (If these were computer-automated merges, the cases are "unmerged.") Sequencing is updated, and any discrepancies between CTR number, Social Security Number, race, date of birth, place of birth, date last seen, vital status, and cause of death are resolved and corrected.

If the analysis results in a determination that the cases are separate primaries (different patients), both reports are saved.

After cases have been consolidated and pass all computerized edit checks, inter-record edit checks are applied periodically to identify and resolve inconsistencies between multiple primary records for one patient.

Facility Feedback
When the analysis of discrepancies identifies variations from coding rules, the issues are reported to the responsible facility for educational purposes.

8. Procedure Manual Maintenance

Current, written documentation of the State Registry's definitions and methods are maintained in a policy and procedure manual, which is provided to all State Registry employees, contract consultants, and employees of reporting facilities. The manual documents the Registry's data set definitions, codes, coding rule interpretations, and procedures. The standards of ACoS, NAACCR, and SEER are incorporated in the manual to the extent possible. Appropriate portions of the documentation will be provided to investigators and users of the data, as needed, to explain definitions and methods.

A Policy and Procedure Manual maintenance system is used for updating the documentation and keeping it current. The system involves monitoring release of new standards, rules, and definitions by ACoS, NAACCR, and SEER. Information from quality control activities are also be used in assessing the need to revise the procedure manual. When revised, dated pages are provided to all Registry staff, contract consultants, and reporting facilities. A library of revisions to the manual is kept at the State Cancer Registry. When revised, dated pages are provided to all Registry staff, contract consultants, and reporting facilities. The State Cancer Registry also maintains an "unusual case" reference file to aid in consistent data collection for difficult cancers.

9. Staff Training and Development

The State Cancer Registry provide training opportunities for employees of the State Registry and employees of reporting facilities. Training programs are developed in cooperation with the Indiana Cancer Registrars Association, Indiana Health Information Management Association, and cancer registry software vendor. Training will provide feedback to State Cancer Registry staff on the quality and effectiveness of services provided to reporting sources and the public.

Training programs are based on standard reference manuals and may address the following areas:

Anatomy and physiology
Medical terminology
Site specific or other topics in oncology
Reporting requirements
Confidentiality and information security
Casefinding
Abstracting/coding/staging
Follow-up
Quality control
Data processing (computer software)
American College of Surgeons updates
Hospital based cancer/tumor registry management
Topics identified through other quality control activities

10. Feedback and Consultation

The results of quality control activities are reported to the applicable data collector to maintain data quality and eliminate recurring errors. Feedback may be written or by telephone call or one-on-one meetings. Feedback to the reporting facilities include the following:

- Information about changes or corrections made to abstracts at the State Registry
- Discrepancy lists resulting from computer or visual edits
- Results of casefinding and reabstracting audits with analysis of discrepancies and recommendations for improvement
- Information from analysis of observed/expected completeness rates.

The abstractor's identification and date completed are required items in the WEBPLUS and are useful in identifying contacts for feedback. A complete list of the abstractors and/or contact person for each hospital is maintained at the State Cancer Registry. When feedback is indicated, the questions are directed to the person on this list.

C. ISSUES RELATED TO QUALITY

1. Timeliness of Data

Data collection must be conducted according to schedule. With the exception of early deaths, no case should be abstracted less than four months after admission. Abstracting too soon may result in the omission of important information from the database if complete information is unavailable at the time of abstracting. Cases are due at the State Registry no later than six months following a confirmed diagnosis. Abstracting too late reduces the usefulness of the cancer registry data and reports. Cases submitted by each reporting source are monitored for timely receipt.

2. Personnel

Data collection in reporting facilities must be performed by knowledgeable and qualified individuals. The individuals serve as the primary abstractors and may be responsible for staff supervision, cancer case auditing, and report writing.

The Commission on Cancer, American College of Surgeons encourages registry staff to maintain Certified Tumor Registrar (CTR) credentials. The State Cancer Registry can provide hospitals with information on how to become a CTR, certified by the National Cancer Registrars Association (NCRA). Information on NCRA is found in Chapter 1 on References.

3. Use of References and Edits

Hospital staff should use available reference materials, many of which are free, rather than trying to memorize codes. Hospitals with computerized registries should ensure all records pass computer edits at the hospital level before sending data to the State. Standard edits, such as the EDITS project system developed by NAACCR, are available from standard setting organizations.

4. Maintenance of Logs and Records

Hospitals must keep documentation by date sent of reports submitted to the State Cancer Registry. Hospitals submitting paper abstracts must submit a legible copy of the original to the State Cancer Registry and keep the original for their records. State Cancer Registry personnel will keep a copy of discrepancy reports returned to the reporting source for completion, clarification, and correction.
*ISCR will no longer accept paper abstracts beginning 1/1/2026

5. Submitting Correction or Follow-Up

Chapter 6 details how to submit corrections and follow-up information. Two correction forms, which permit changes or deletions to be made to the Hospital Abstract Form, are explained. The Correction and Follow-Up Form also allows reporting of annual follow-up information.

6. Other Resources

Further information on quality control procedures may be obtained by requesting Volume I: Cancer Program Standards published by the Commission on Cancer, American College of Surgeons. The State Cancer Registry complies with the NAACCR Standards for Cancer Registries, Volume III: Standards for Completeness, Quality, Analysis, and Management of Data.

CHAPTER 8: CONFIDENTIALITY

A. OVERVIEW

1. Purpose

The State Cancer Registry is committed to preserving the confidentiality of information obtained for medical, educational, research, and statistical purposes. Confidentiality policies and procedures are maintained in all phases of the State Registry operations in order to:

- Protect the privacy of individual patients;
- Protect the privacy of the facilities reporting the cases;
- Abide by applicable confidentiality-protecting legislation or administrative rules.

2. Definition

Confidential data includes any information that identifies a specific patient, health care professional, or institution. The obligation to protect confidentiality extends indefinitely, even after the death of the patient.

Legal requirements for confidentiality are described in IC 16-38-2-(4-7) and 410 IAC 21-1-5, found in Appendix A.

B. RESPONSIBILITY

1. Reporting Source (Hospital or Other Health Care Provider)

The reporting source (hospital or other health care provider) is responsible for protecting the confidentiality of registry data collected and maintained on site and for submitting data to the State Registry in a way that protects confidentiality. The hospital should develop and implement confidentiality policies and procedures that address staff training, access control, record/abstract handling and storage, and release of registry data.

Paper abstracts must be handled and stored in a way that prevents unauthorized individuals from viewing confidential data. Information maintained in computerized systems must be protected by physical and electronic measures to control access to confidential data. Hospitals should mail copies of completed abstracts and/or patient record copies promptly to the State Registry, following the instructions in Chapter 3 of this manual for sealing and labeling the container and for keeping records of the cases submitted. *ISCR will no longer accept paper abstracts beginning 1/1/2026

2. State Registry

The Program Director is ultimately responsible for information security at the State Registry. This responsibility includes ensuring that State Registry staff are accountable for compliance with the confidentiality policies and procedures of this chapter.

C. STATE REGISTRY POLICIES AND PROCEDURES

1. Staff Awareness

a. All State Registry personnel and consultants receive specific training about the confidentiality of registry information and their responsibilities.

b. All personnel handling or having access to cancer registry data are required to sign a Confidentiality Agreement. This includes staff from other departments, sections, or programs that are outside the State Cancer Registry but within the Indiana Department of Health. The agreement documents that the employee has read and understands the State Cancer Registry policies for handling the data, agrees to abide by the policies, and is aware that failure to comply with any of these requirements constitutes a class A misdemeanor which

will result in disciplinary action in accordance with State policies. The agreement remains in effect after cessation of employment. A copy of the Confidentiality Agreement is available from the State Cancer Registry upon request.

2. Access Control

a. A current, written list of persons with legitimate access to confidential cancer data is kept in the State Cancer Registry office. The nature and extent of their access to registry data are defined and are restricted to the information needed to do his/her job.

b. All file cabinets where confidential data are stored in open areas are locked except when in use by authorized State Cancer Registry staff. The file room designated for the Cancer Registry Program is locked except when authorized State Cancer Registry staff are present.

c. Employees are provided with the equipment for ensuring the physical security of confidential information. Confidential patient abstracts are stored in locked file cabinets. Backup tapes of the statewide database are stored in a locked, fireproof safe.

d. Field staff maintain abstracts and/or printed reports in locked briefcases which are kept in a secure place when unattended. Access to confidential information is limited to authorized hospital personnel. Discussions regarding patient records occur only in settings where privacy is assured.

e. The computer system provides access only to authorized individuals. The system has a three tiered level of security.

1) The first level is the user Login Name. Each central registry staff logging into the network file server must enter his/her unique user login name.

2) The second level is the confidential password, established by the user. The password is altered on a regular basis and when there is concern that security may be in jeopardy.

* *After September 10, 2024, the state cancer registry software is SEER Data Management System (SEER DMS).*

When a user is no longer employed at the State Registry, his/her password and access codes are deactivated immediately.

f. Disclosure or sharing of codes, numbers, or names used to access the computer is strictly prohibited.

g. When printed reports containing confidential information are no longer needed, they are disposed of by shredding.

3. Data Collection and Management

a Electronically Submitted Data

The State supports the programs described below that ensure the secure transmission of electronic cancer data by reporting facilities.

1) The FTP Program
The preferred method for submitting data is the ISCR FTP Program that encrypts the facility's data file and sends it to the ISCR through the Internet using the File Transfer Protocol (FTP). If the facility prohibits or limits the use of FTP, the program can also send the encrypted file as an e-mail attachment. The method meets government security requirements.

2) Web Plus

An alternate method is the Web Plus program that securely uploads the facility's data file through a browser. The method also meets government security requirements.

b. Submitting on Diskettes
Effective July 2009 the State Cancer Registry no longer processes data submitted on diskettes. Diskettes received and processed prior to this date have been securely backed up to a server and have been destroyed by the Commission on Public Records.

c. Abstract Forms & Paper Copies of Medical Records
Mail labeled "CONFIDENTIAL MEDICAL INFORMATION" is opened only by designated State Registry staff. Such mail is kept in a secure location before and after it is processed. State Cancer Registry personnel stamp each form with the date received and maintain a register by hospital documenting the date the batch was received, the date the batch was entered, the number of forms enclosed, and the accession year for the cases. The State Registry retains the abstract forms and registers indefinitely. After processing, abstract forms are filed by hospital, accession year, and accession number. *ISCR will no longer accept paper abstracts beginning 1/1/2026

d. Quality Control Communications
When State Registry quality control (QC) activities require returning abstracts, inquiry forms, or discrepancy lists to reporting facilities, the mailings are carefully sealed and labeled "CONFIDENTIAL MEDICAL INFORMATION." When telephone calls are made to address QC issues, reasonable efforts are made to ensure the conversations are private and addressed to an authorized data collector at the reporting facility. When QC communications are transmitted by electronic mail (e-mail), patient-identifying information will be limited to accession numbers. Patient-identifying e-mail received at the State Registry is treated with the same level of security and confidentiality as other confidential medical information.

e. Facsimile Transmission
Confidential information should be transmitted via facsimile only when urgently needed for patient care. When such transmission is necessary, the cover page will include a confidentiality notice that indicates the information is confidential and limits its use. After transmission, a follow-up call will be made to verify that the information was sent to the appropriate destination.

4. Disaster Recovery
The Indiana Department of Health Information Technology Services is responsible for the comprehensive disaster recovery plan that includes the State Cancer Registry data and systems. The plan includes frequent and regular backup, off-site storage, and procedures for retrieval. It is designed to protect operating systems, applications, and data.

5. Sabotage
Anti-virus software is used to help detect and block computer viruses and other forms of sabotage.

6. Release of Registry Data
a. Hospital Requests
Confidential information may be released by authorized State Registry personnel to health care providers and institutions upon verbal or written request and without further review procedures under either of the following circumstances:
1. The requestor is directly involved in the care or follow-up of the patient;
2) The information requested is from the hospital's own registry.

b. Patient or Individual Requests
The State Cancer Registry staff do not respond to individuals requesting whether or not the State Registry contains information about them. Individuals making such requests are referred to their treating physician.

c. Physician Requests
Confidential information may be released to physicians and local health officers for diagnostic and treatment purposes if the patient signs a written consent and the patient's attending physician gives verbal or written consent to the release.

d. Other States
Pursuant to IC 16-38-2-7, effective May 15, 1988, the Indiana Cancer Registry may release confidential information concerning individual cancer patients to the cancer registry of another state under the following condition: The other state has entered into a reciprocal agreement with the State Cancer Registry which provides that information that identifies a patient will not be released to any other person without the written consent of the patient.

e. Other External Requests
1) Requests for use of confidential data are handled in accordance with IC 16-38-2-(5-7).

2) Confidential cancer registry data will not be made available for the following purposes:

a) Businesses that are trying to market a product to cancer patients;
b) Health care institutions that are trying to recruit new patients;
c) Insurance companies that are trying to determine the medical status of a patient.

3) Requests for State Cancer Registry data for other purposes, such as research projects, are processed as outlined below.

a) The request must be submitted in writing and include the following information:
- The purpose for which data are needed or an outline of the proposed research with a justification of the need for the data;
- The information required;
- The names of the persons who will have access to the confidential information;
- The time period for which the data are needed.

A record is kept of the date and type of all requests.

b) The written request is submitted to the Indiana Department of Health Data Request Committee for review. The committee must approve the request before release can be made. The State Cancer Registry reserves the right to limit the amount of data to be provided to an individual requestor.

c) If the request is approved, researchers must sign an agreement acknowledging responsibility to maintain patient confidentiality, cite the source of the data in any publication or presentation, and provide the State Cancer Registry with copies of any publications or presentations that may use the data prior to their release. Violation of any part of this agreement shall prevent further access to the data, and shall result in a letter of reprimand to the chief executive officer of the researcher's institution. In addition, other researchers at the institution may be denied access to the data until the Program Director is assured that no other violations will occur.

All requestors must assure:
- That he/she is bound by the principles of confidentiality observed by the personnel of the State Cancer Registry;
- That the data will not be used for purposes other than those agreed upon at the time of release;
- That the data will not be released to unauthorized individuals or parties; and
- That data that are no longer needed for the designated purpose will be returned or destroyed.

f. State Initiated Requests

The Program Director monitors all state initiated research activities to ensure that only relevant activities are undertaken. State affiliated researchers are expected to abide by the same restrictions as outside researchers.

APPENDIX A: LEGISLATION AND REGULATIONS

INDIANA CODE 16-38-2
Public Law 2-1993, Section 21

IC 16-38-2-1 Cancer registry; establishment

Sec. 1. (a) The state department shall establish a cancer registry for the purpose of:
(1) recording:
(A) all cases of malignant disease; and
(B) other tumors and precancerous diseases required to be reported by:
(i) federal law or federal regulation; or
(ii) the National Program of Cancer Registries;
that are diagnosed or treated in Indiana; and
(2) compiling necessary and appropriate information concerning those cases, as determined by the state department; in order to conduct epidemiologic surveys of cancer and to apply appropriate preventive and control measures.
(b) The department may contract for the collection and analysis of, and the research related to, the epidemiologic data compiled under this chapter.

As added by P.L. 2-1993, SEC.21. Amended by P.L. 93-2001, SEC.1; P.L. 17-2004, SEC.2.

IC 16-38-2-2 Development of registry from existing data

Sec. 2. The state department shall, to the greatest extent possible, utilize information compiled by public or private cancer registries in the development of a statewide cancer registry under this chapter.

As added by P.L. 2-1993, SEC.21.

IC 16-38-2-3 Reports

Sec. 3. (a) The following persons shall report to the cancer registry each confirmed case of cancer and other tumors and precancerous diseases required to be recorded under section 1 of this chapter:
(1) Physicians.
(2) Dentists.
(3) Hospitals.
(4) Medical laboratories.
(5) Ambulatory outpatient surgical centers.
(6) Health facilities.
(b) A person required to report information to the state cancer registry under this section may utilize, when available:
(1) information submitted to any other public or private cancer registry; or
(2) information required to be filed with federal, state, or local agencies; when completing reports required by this chapter. However, the state department may require additional, definitive information.

As added by P.L. 2-1993, SEC.21. Amended by P.L. 17-2004, SEC.3.

IC 16-38-2-4 Confidentiality

Sec. 4. Except as provided in sections 5, 6, and 7 of this chapter, information obtained under this chapter by the state department concerning individual cancer patients is for the confidential use of the state department only.

As added by P.L. 2-1993, SEC.21.

IC 16-38-2-5 Access to confidential information for research purposes

Sec. 5. The state department shall grant any person involved in a legitimate research activity access to confidential information concerning individual cancer patients obtained by the state department under this chapter if all of the following conditions are met:
(1) The person conducting the research provides written information about the following:
(A) The purpose of the research project.
(B) The nature of the data to be collected and how the researcher intends to analyze the data.
(C) The records the researcher desires to review.
(D) The safeguards the researcher will take to protect the identity of the patients whose records the researcher will be reviewing.
(2) The proposed safeguards are adequate to protect the identity of each patient whose records will be reviewed.
(3) An agreement is executed between the state department and the researcher that meets all of the following conditions:
(A) Specifies the terms of the researcher's use of the records.
(B) 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.
As added by P.L. 2-1993, SEC.21.

IC 16-38-2-6 Additional information requests; individual patients; consents

Sec. 6. Researchers may, with the approval of the state department, use the names of individual cancer patients when requesting additional information for research purposes or soliciting an individual patient's participation in a research project. However, if a researcher requests additional information for an individual cancer patient's participation in a research project, the researcher must 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 must then obtain the individual cancer patient's written consent by having the patient complete a release of confidential medical information form.
As added by P.L. 2-1993, SEC.21.

IC 16-38-2-7 Release of confidential information

Sec. 7 The state department may release confidential information concerning individual cancer patients to the following:
(1) The cancer registry of another state if the following conditions are met:
(A) The other state has entered into a reciprocal agreement with the state department.
(B) The agreement provides that information that identifies a patient will not be released to any other person without the written consent of the patient.
(2) Physicians and local health officers for diagnostic and treatment purposes if the following conditions are met:
(A) The patient's attending physician gives oral or written consent to the release of the information.
(B) The patient gives written consent by completing a release of confidential information form.
As added by P.L. 2-1993, SEC.21.

IC 16-38-2-8 Immunity from liability

Sec. 8. A person who reports information to the cancer registry system under this chapter is immune from any civil or criminal liability that might otherwise be imposed because of the release of what is otherwise confidential information.
As added by P.L. 2-1993, SEC.21.

IC 16-38-2-9 Epidemiological information; release

Sec. 9 This chapter does not prevent the release to any interested person of epidemiological information that does not identify individual cancer patients.

As added by P.L. 2-1993, SEC.21.

IC 16-38-2-10 Administrative rules

Sec. 10. The state department shall adopt rules under IC 4-22-2 necessary to carry out this chapter.

As added by P.L. 2-1993, SEC.21.

IC 16-38-2-11 Annual report

Sec. 11. Not later than December 31 of each year, the department shall publish and make available to the public an annual report summarizing the information collected under this chapter during the previous calendar year.

As added by P.L.93-2001, SEC.2. Amended by P.L. 17-2004, SEC.4.

INDIANA ADMINISTRATIVE CODE – 410 IAC 21-1

ARTICLE 21. REPORTING

Rule 1. State Cancer Registry

410 IAC 21-1-1 Definitions
Authority: IC 16-38-2-10
Affected: IC 16-38-2

Sec. 1. As used in 410 IAC 21-1:

"Cancer registry" means a mechanism by which data relating to all cases of malignant disease that occur in Indiana residents is recorded and, necessary and appropriate information is compiled concerning those cases as determined by the board, in order to conduct epidemiologic surveys of cancer and to apply appropriate preventive and control measures.

"Confirmed case" means the best evidence available for determining the nature of malignant disease using the following methods and codes: 1 = positive histology; 2 = positive exfoliative histology in the absence of positive histology; (3 is vacant) 4 = positive microscopic confirmation not otherwise specified (NOS); (5 is vacant) 6 = direct visualization without microscopic confirmation; 7 = radiography without microscopic confirmation; 8 = clinical diagnosis (other than 6 or 7) including gross examination at autopsy; and 9 = unspecified whether or not microscopically confirmed, unknown. This is a priority series with code 1 taking precedence. Each number takes priority over all higher numbers (i.e., 1 over 4, and 5 over 9 etc.).

"Data set" means all clinical, pathological *[sic.,]* therapeutic and demographic information defined in 410 IAC 21-1-3 and 410 IAC 21-1-4.

"ICD-O" means International Classification of Diseases for Oncology, 1976, World Health Organization publication, Organisation Mondiale De La Sante, 1211, Geneva 27, Switzerland.

"Indiana resident" means an individual domiciled in the state of Indiana.

"Malignant disease" means confirmed cases of cancer enumerated in the ICD-O excluding superficial, squamous and basal cell carcinomas of the skin.

"Patient" means any individual who is ill, or undergoing diagnosis or treatment for disease by a dentist, medical laboratory, physician or hospital.

"Person" means an individual, association, partnership, corporation, or governmental entity.

"State board" means the Indiana state board of health. *(Indiana State Department of Health; 410 IAC 21-1-1; filed Nov 7, 1986, 3:30 pm: 10 IR 420; readopted filed Jul 11, 2001, 2:23 p.m.: 24 IR 4234)*

410 IAC 21-1-2 General requirements
Authority: IC 16-38-2-10
Affected: IC 5-15-5.1-5; IC 16-38-2

Sec. 2. (a) All physicians, dentists, hospitals and medical laboratories shall report all confirmed cases of cancer occurring in Indiana residents who have been diagnosed or treated in Indiana, to the state board cancer registry.

(b) Any health care provider reporting to a public or private cancer registry on September 1, 1985 shall make available to the state cancer registry, all data as required under 410 IAC 21-1-3 (hospitals) or 410 IAC 21-1-4 (physicians, dentists and medical laboratories) upon the effective date of 410 IAC 21-1.

(c) The state board shall assure state cancer registry computer compatibility for any health care provider who on or before the effective date of 410 IAC 21-1 elects to transmit the required data by way of a computerized mechanism.
(d) Any health care provider who, after the effective date of 410 IAC 21-1, establishes a computerized mechanism for the purpose of transmitting abstracted data sets via computer link up, tape transfer, or direct interface, shall be responsible for assuring system compatibility with the state board cancer registry.
(e) Any health care provider who elects to transfer abstracted data sets to the state cancer registry in paper form, shall utilize an abstract form designed or approved by the state board pursuant to IC 5-15-5.1-5. *ISCR will no longer accept paper abstracts beginning 1/1/2026
(f) All manually prepared data sets shall be mailed or delivered by the health care provider to the state cancer registry.
(g) All health care providers not reporting to a public or private cancer registry on September 1, 1985, shall begin submitting data on cases diagnosed on or after January 1, 1987 to the state cancer registry as set out in 410 IAC 21-1-3 (hospitals) or 410 IAC 21-1-4 (physicians, dentists and medical laboratories), no later than six (6) months following the date of such diagnosis.
(h) Reports of confirmed cases of malignant disease shall be submitted to the state cancer registry within six (6) months following a confirmed diagnosis. *(Indiana State Department of Health; 410 IAC 21-1-2; filed Nov 7, 1986, 3:30 pm: 10 IR 420; readopted filed Jul 11, 2001, 2:23 p.m.: 24 IR 4234)*

410 IAC 21-1-3 Hospitals
Authority: IC 16-38-2-10
Affected: IC 16-38-2

Sec. 3. (a) All hospitals shall submit abstracted data sets to the state board cancer registry which shall include but not be limited to the following data items:

(1) site code
(2) accession number
(3) sequence number
(4) accession year
(5) social security number
(6) medical record number
(7) full name (including maiden name)
(8) home address, city, county, state and zip code
(9) phone number
(10) date of birth
(11) sex
(12) race
(13) class of case
(14) admission date
(15) follow-up physician
(16) discharge date
(17) date of initial diagnosis
(18) topography code
(19) paired organ involvement
(20) histology code
(21) tumor grade
(22) diagnostic confirmation
(23) tumor size (largest dimension)
(24) number of positive nodes
(25) number of nodes examined
(26) sites of distant metastasis
(27) general summary stage
(28) TNM stage
(29) AJCC stage group
(30) TNM staging basis
(31) date and method of first course of treatment

(32) subsequent therapies/treatments (dates and methods)

(b) Available updated information regarding all elements enumerated in 410 IAC 21-1-3(a) shall be reported to the state board cancer registry each twelve (12) month period following the initial reporting of the disease. *(Indiana State Department of Health; 410 IAC 21-1-3; filed Nov 7, 1986, 3:30 pm: 10 IR 421; readopted filed Jul 11, 2001, 2:23 p.m.: 24 IR 4234)*

410 IAC 21-1-4 Physicians, dentists and medical laboratories
Authority: IC 16-38-2-10
Affected: IC 16-38-2

Sec. 4. (a) Any physician, dentist or medical laboratory who diagnoses a case of malignant disease when such case is not referred to a hospital for further diagnosis or treatment, shall submit required data sets to the state cancer registry. Such data sets shall include but not be limited to the following available data items:

(1) patient's full name (including maiden name)
(2) patient's address (including city, county, state and zip code)
(3) social security number
(4) date of birth
(5) sex
(6) race
(7) date of diagnosis
(8) topography
(9) morphology
(10) diagnostic confirmation
(11) hospital referred to
(12) physician, dentist or laboratory license number
(13) physician, dentist or laboratory name, address and phone number

(b) Physicians, dentists and medical laboratories whose offices are located within the confines of a hospital or, who are employed or contracted by a hospital and who diagnose or treat patients for malignant disease, shall not be required to report cases of malignant disease under 410 IAC 21-1-4. Such cases shall be reported in accordance with 410 IAC 21-1-3. *(Indiana State Department of Health; 410 IAC 21-1-4; filed Nov 7, 1986, 3:30 pm: 10 IR 421; readopted filed Jul 11, 2001, 2:23 p.m.: 24 IR 4234)*

410 IAC 21-1-5 Security and confidentiality of data
Authority: IC 16-38-2-10
Affected: IC 5-14-3-10; IC 16-38-2

Sec. 5. (a) The state board shall assure confidentiality of patient record data when entering, retrieving, reviewing and utilizing such data.

(b) The state board shall take all precautions and security measures necessary in order to protect the cancer registry data from intrusion or misuse by unauthorized individuals, and to preserve the right to privacy of individual patients maintained on the registry.
(c) Pursuant to IC 5-14-3-10, any public employee or official, or any employee or officer of a contractor or subcontractor of a public agency who knowingly or intentionally discloses the identity of a patient maintained on the state cancer registry system to a person not authorized to receive such information, commits a Class A misdemeanor. Any public employee shall be disciplined in accordance with the personnel policies of the agency by which he is employed if he intentionally, knowingly, or recklessly discloses or fails to protect the identity of patients maintained on the state cancer registry system.
(d) A person who reports information to the cancer registry system in accordance with 410 IAC 21-1, is immune from any civil or criminal liability that might otherwise be imposed because of release of what is otherwise confidential information. *(Indiana State Department of Health; 410 IAC 21-1-5; filed Nov 7, 1986, 3:30 pm: 10 IR 422; readopted filed Jul 11, 2001, 2:23 p.m.: 24 IR 4234)*

410 IAC 21-1-6 Cancer registry reports
Authority: IC 16-38-2-10
Affected: IC 16-38-2

Sec. 6. (a) The state board shall make available to all hospitals licensed under IC 16-10-1 *[IC 16-10 was repealed by P.L.2-1993, SECTION 209, effective April 30, 1993.]*, a comprehensive annual report which outlines the trends of malignant disease in Indiana and focuses on specific elements of special study regarding the disease.

(b) Hospitals, physicians, dentists, laboratories and other persons may request and be provided with special reports from the state cancer registry, providing the data requested does not disclose the identity of a patient. *(Indiana State Department of Health; 410 IAC 21-1-6; filed Nov 7, 1986, 3:30 pm: 10 IR 422; readopted filed Jul 11, 2001, 2:23 p.m.: 24 IR 4234)*

Public Law 102-515
102d Congress

An Act

Oct. 24, 1992
[S. 3312]

Entitled the "Cancer Registries Amendment Act."

Cancer Registries Amendment Act.
Diseases.
Health and health care.
42 USC 201 note.
42 USC 280e note.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Cancer Registries Amendment Act."

SEC.2. FINDINGS AND PURPOSE

(a) FINDINGS.-Congress finds that-

(1) cancer control efforts, including prevention and early detection, are best addressed locally by State health departments that can identify unique needs;

(2) cancer control programs and existing statewide population-based cancer registries have identified cancer incidence and cancer mortality rates that indicate the burden of cancer for Americans is substantial and varies widely by geographic location and by ethnicity;

(3) Statewide cancer incidence and cancer mortality data, can be used to identify cancer trends, patterns, and variation for directing cancer control intervention;

(4) the American Association of Central Cancer Registries (AACCR) cites that of the 50 States, approximately 38 have established cancer registries, many are not statewide and 10 have no cancer registry; and

(5) AACCR also cites that of the 50 States, 39 collect data on less than 100 percent of their population, and less than half have adequate resources for insuring minimum standards for quality and for completeness of case information.

(b) PURPOSE.-It is the purpose of this Act to establish a national program of cancer registries.

SEC. 3. NATIONAL PROGRAM OF CANCER REGISTRIES.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following new part:

"PART M-NATIONAL PROGRAM OF CANCER REGISTRIES"

42 USC 280e.

"SEC. 399H. NATIONAL PROGRAM OF CANCER REGISTRIES.

"(a) IN GENERAL.-The Secretary, acting through the Director of the Centers for Disease Control, may make grants to States, or may make grants or enter into contracts with academic or nonprofit organizations designated by the State to operate the State's cancer registry in lieu of making a grant directly to the State, to support the operation of population-based, statewide cancer registries in order to collect, for each form of in-situ and invasive cancer (with the exception of basal cell and squamous cell carcinoma of the skin), data concerning-

"(1) demographic information about each case of cancer;

"(2) information on the industrial or occupational history of the individuals with the cancers, to the extent such information is available from the same record;

"(3) administrative information, including date of diagnosis and source of information;

"(4) pathological data characterizing the cancer, including the cancer site, stage of disease (pursuant to Staging Guide), incidence, and type of treatment; and

"(5) other elements determined appropriate by the Secretary.

"(b) MATCHING FUNDS.-

"(1) IN GENERAL.-The Secretary may make a grant under subsection (a) only if the State, or the academic or nonprofit private organization designated by the State to operate the cancer registry of the State, involved agrees, with respect to the costs of the program, to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is not less than 25 percent of such costs or $1 for every $3 of Federal funds provided in the grant.

"(2) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION; MAINTENANCE OF EFFORT.-

"(A) Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

"(B) With respect to a State in which the purpose described in subsection (a) is to be carried out, the Secretary, in making a determination of the amount of non-Federal contributions provided under paragraph (1), may include only such contributions as are in excess of the amount of such contributions made by the State toward the collection of data on cancer for the fiscal year preceding the first year for which a grant under subsection (a) is made with respect to the State. The Secretary may decrease the amount of non-Federal contributions that otherwise would have been required by this subsection in those cases in which the State can demonstrate that decreasing such amount is appropriate because of financial hardship.

"(c) ELIGIBILITY FOR GRANTS.-

"(1) IN GENERAL.-No grant shall be made by the Secretary under subsection (a) unless an application has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such a manner, and be accompanied by such information, as the Secretary may specify. No such application may be approved unless it contains assurances that the applicant will use the funds provided only for the

purposes specified in the approved application and in accordance with the requirements of this section, that the application will establish such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement and accounting of Federal funds paid to the applicant under subsection (a) of this section, and that the applicant will comply with the peer review requirements under sections 491 and 492.

"(2) ASSURANCES.-Each applicant, prior to receiving Federal funds under subsection (a), shall provide assurances satisfactory to the Secretary that the applicant will-

"(A) provide for the establishment of a registry in accordance with subsection (a);

"(B) comply with appropriate standards of completeness, timeliness, and quality of population-based cancer registry data;

"(C) provide for the annual publication of reports of cancer data under subsection (a); and

"(D) provide for the authorization under State law of the statewide cancer registry, including promulgation of regulations providing-

"(i) a means to assure complete reporting of cancer cases (as described in subsection (a)) to the statewide cancer registry by hospitals or other facilities providing screening, diagnostic or therapeutic services to patients with respect to cancer;

"(ii) a means to assure the complete reporting of cancer cases (as defined in subsection (a)) to the statewide cancer registry by physicians, surgeons, and all other health care practitioners diagnosing or providing treatment for cancer patients, except for cases directly referred to or previously admitted to a hospital or other facility providing screening, diagnostic or therapeutic services to patients in that State and reported by those facilities;

"(iii) a means for the statewide cancer registry to access all records of physicians and surgeons, hospitals, outpatient clinics, nursing homes, and all other facilities, individuals, or agencies providing such services to patients which would identify cases of cancer or would establish characteristics of the cancer, treatment of the cancer, or medical status of any identified patient;

"(iv) for the reporting of cancer case data to the statewide cancer registry in such a format, with such data elements, and in accordance with such standards of quality timeliness and completeness, as may be established by the Secretary;

"(v) for the protection of the confidentiality of all cancer case data reported to the statewide cancer registry, including a prohibition on disclosure to any person of information reported to the statewide cancer registry that identifies, or could lead to the identification of, an individual cancer patient, except for disclosure to other State cancer registries and local and State health officers;

"(vi) for a means by which confidential case data may in accordance with State law be disclosed to cancer researchers for the purposes of cancer prevention, control and research;

"(vii) for the authorization or the conduct, by the statewide cancer registry or other persons and organizations, of studies utilizing statewide cancer registry data, including studies of the sources and causes of cancer, evaluations of the cost, quality, efficacy, and appropriateness of diagnostic, therapeutic, rehabilitative, and preventative services and programs relating to cancer, and any other clinical, epidemiological, or other cancer research; and

"(viii) for protection for individuals complying with the law, including provisions specifying that no person shall be held liable in any civil action with respect to a cancer case report provided to the statewide cancer registry, or with respect to access to cancer case information provided to the statewide cancer registry.

"(d) RELATIONSHIP TO CERTAIN PROGRAMS.-

"(1) IN GENERAL.-This section may not be construed to act as a replacement for or diminishment of the program carried out by the Director of the National Cancer Institute and designated by such Director as the Surveillance, Epidemiology, and End Results Program (SEER).

"(2) SUPPLANTING OF ACTIVITIES.-In areas where both such programs exist, the Secretary shall ensure that SEER support is not supplanted and that any additional activities are consistent with the guidelines provided for in subsection (c)(2) (C) and (D) and are appropriately coordinated with the existing SEER program.

"(3) TRANSFER OF RESPONSIBILITY.- The Secretary may not transfer administration responsibility for such SEER program from such Director.

"(4) COORDINATION.-To encourage the greatest possible efficiency and effectiveness of Federally supported efforts with respect to the activities described in this subsection, the Secretary shall take steps to assure the appropriate coordination of programs supported under this part with existing Federally supported cancer registry programs.

"(e) REQUIREMENT REGARDING CERTAIN STUDY ON BREAST CANCER.-In the case of a grant under subsection (a) to any State specified in section 399K(b), the Secretary may establish such conditions regarding the receipt of the grant as the Secretary determines are necessary to facilitate the collection of data for the study carried out under section 399C.

"SEC. 399I. PLANNING GRANTS REGARDING REGISTRIES. 42 USC 280e-1.

"(a) IN GENERAL.-

"(1) STATES.-The Secretary, acting through the Director of the Centers for Disease Control, may make grants to States for the purpose of developing plans that meet the assurances required by the Secretary under section 399B(c)(2).

"(2) OTHER ENTITIES.-For the purpose described in paragraph (1), the Secretary may make grants to public entities other than States and to nonprofit private entities. Such a grant may be made to an entity only if the State in which the purpose is to be carried out has certified that the State approves the entity as qualified to carry out the purpose.

"(b) APPLICATION.-The Secretary may make a grant under subsection (a) only if an application for the grant is submitted to the Secretary, the application contains the certification required in subsection (a)(2) (if the application is for a grant under such subsection), and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

42 USC 280e-2.

"SEC. 399J. TECHNICAL ASSISTANCE IN OPERATIONS OF STATEWIDE CANCER REGISTRIES.

"The Secretary, acting through the Director of the Centers for Disease Control, may, directly or through grants and contracts, or both, provide technical assistance to the States in the establishment and operation of statewide registries, including assistance in the development of model legislation for statewide cancer registries and assistance in establishing a computerized reporting and data processing system.

42 USC 280e-3.

"SEC. 399K. STUDY IN CERTAIN STATES TO DETERMINE THE FACTORS CONTRIBUTING TO THE ELEVATED BREAST CANCER MORTALITY RATES.

"(a) IN GENERAL.-Subject to subsections (c) and (d), the Secretary, acting through the Director of the National Cancer Institute, shall conduct a study for the purpose of determining the factors contributing to the fact that breast cancer mortality rates in the States specified in subsection (b) are elevated compared to rates in other States.

"(b) RELEVANT STATES.-The States referred to in subsection (a) are Connecticut, Delaware, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, Vermont, and the District of Columbia.

"(c) COOPERATION OF STATE.-The Secretary may conduct the study required in subsection (a) in a State only if the State agrees to cooperate with the Secretary in the conduct of the study, including providing information from any registry operated by the State pursuant to section 399H(a).

"(d) PLANNING, COMMENCEMENT, AND DURATION.-The Secretary shall, during each of the fiscal years 1993 and 1994, develop a plan for conducting the study required in subsection (a). The study shall be initiated by the Secretary not later than fiscal year 1994, and the collection of data under the study may continue through fiscal year 1998.

"(e) REPORT.-Not later than September 30, 1999, the Secretary shall complete the study required in subsection (a) and submit to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, a report describing the findings and recommendations made as a result of the study.

"SEC. 399L. AUTHORIZATION OF APPROPRIATIONS. 42 USC 280e-4.

"(a) REGISTRIES.-For the purpose of carrying out this part, the Secretary may use $30,000,000 for each of the fiscal years 1993 through 1997. Out of any amounts used for any such fiscal year, the Secretary may obligate not more than 25 percent for carrying out section 399I, and not more than 10 percent may be expended for assessing the accuracy, completeness and quality of data collected, and not more than 10 percent of which is to be expended under subsection 399J.

"(b) BREAST CANCER STUDY.-Of the amounts appropriated for the National Cancer Institute under subpart 1 of part C of title IV for any fiscal year in which the study required in section 399K is being carried out, the Secretary shall expend not less than $1,000,000 for the study."

Approved October 24, 1992.

Authorization extended through 1998.

Public Law 107-260

Benign Brain Tumor Cancer Registries Amendment Act

SECTION 1. SHORT TITLE.

This Act may be cited as the "Benign Brain Tumor Cancer Registries Amendment Act."

SEC. 2. NATIONAL PROGRAM OF CANCER REGISTRIES; BENIGN BRAIN-RELATED TUMORS AS ADDITIONAL CATEGORY OF DATA COLLECTED.

(a) IN GENERAL- Section 399B of the Public Health Service Act (42 U.S.C. 280e), as redesignated by section 502(2)(A) of Public Law 106-310 (114 Stat. 1115), is amended in subsection (a)--

(1) by redesignating paragraphs (1) through (5) as subparagraphs (A) through (E), respectively, and indenting appropriately;

(2) by striking "(a) IN GENERAL- The Secretary" and inserting the following:

(a) IN GENERAL-

(1) STATEWIDE CANCER REGISTRIES- The Secretary;

(3) in the matter preceding subparagraph (A) (as so redesignated), by striking "population-based" and all that follows through "data" and inserting the following: population-based, statewide registries to collect, for each condition specified in paragraph (2)(A), data; and

(4) by adding at the end the following:

(2) CANCER; BENIGN BRAIN-RELATED TUMORS-

(A) IN GENERAL- For purposes of paragraph (1), the conditions referred to in this paragraph are the following:

(i) Each form of in-situ and invasive cancer (with the exception of basal cell and squamous cell carcinoma of the skin), including malignant brain-related tumors.

(ii) Benign brain-related tumors.

(B) BRAIN-RELATED TUMOR- For purposes of subparagraph (A):

(i) The term "brain-related tumor" means a listed primary tumor (whether malignant or benign) occurring in any of the following sites:

(I) The brain, meninges, spinal cord, cauda equina, a cranial nerve or nerves, or any other part of the central nervous system.

(II) The pituitary gland, pineal gland, or craniopharyngeal duct.

(ii) The term "listed," with respect to a primary tumor, means a primary tumor that is listed in the International Classification of Diseases for Oncology (commonly referred to as the ICD-O).

(iii) The term "International Classification of Diseases for Oncology" means a classification system that includes topography (site) information and histology (cell type information) developed by the World Health Organization, in collaboration with international centers, to promote international comparability in the collection, classification, processing, and presentation of cancer statistics. The

ICD-O system is a supplement to the International Statistical Classification of Diseases and Related Health Problems (commonly known as the ICD) and is the standard coding system used by cancer registries worldwide. Such term includes any modification made to such system for purposes of the United States. Such term further includes any published classification system that is internationally recognized as a successor to the classification system referred to in the first sentence of this clause.

(C) STATEWIDE CANCER REGISTRY- References in this section to cancer registries shall be considered to be references to registries described in this subsection.

(b) APPLICABILITY- The amendments made by subsection (a) apply to grants under section 399B of the Public Health Service Act for fiscal year 2002 and subsequent fiscal years, except that, in the case of a State that received such a grant for fiscal year 2000, the Secretary of Health and Human Services may delay the applicability of such amendments to the State for not more than 12 months if the Secretary determines that compliance with such amendments requires the enactment of a statute by the State or the issuance of State regulations.

APPENDIX B: REPORTABLE LIST

The definitions in the State Cancer Registry Policy and Procedure Manual describe reportable cases in terms of their *ICD-O-3* topography and morphology codes. These pages contain all reportable malignancies with an *International Classification of Diseases of Oncology,* Third Edition (*ICD-O-3*) behavior code of /2 or /3. Diagnoses with a behavior code of /0 (benign) or /1 (borderline) are not reportable to the State Cancer Registry except for intracranial and central nervous tumors diagnosed 01/01/2004 and later. See section B of this appendix for the reportable list of benign and borderline intracranial and central nervous tumors.

A. REPORTABLE MALIGNANCIES

Conditions are to be reported if the diagnosis includes the words:

Cancer
Carcinoma (**EXCEPT:** certain basal or squamous cell carcinomas of the skin, CIS, CIN III, and PIN III, as described in Chapter 3)
Leukemia
Lymphoma
Malignant
Melanoma
Sarcoma

The following terms, used as adjectives, are also to be reported when used in the description of a malignancy:

Anaplastic
Histiocytic
Intraepithelial
Keratinizing
Medullary
Moderately differentiated
Non-keratinizing
Poorly differentiated
Small cell
Well differentiated

The morphologic terms listed below are malignancies and should be reported. Special formatting identifies changes and is explained below.

- Underlined terms represent new 2025 morphology terms published for *ICD-O-3.2* with site codes, if applicable (when a histology code is site-specific).
- Highlighted items are terms that changed behavior in 2023 *ICD-O-3.2* and are reportable if diagnosed on or after January 1, 2025.
- A ~~strikethrough~~ indicates a term that changed behavior in 2023 *ICD-O-3.2* and is not reportable if diagnosed on or after January 1, 2025.
- See the 2018 Policy and Procedure Manual Appendix B for changes between *ICD-O-2* and *ICD-O-3,* as well as reportable terms designated as new in 2018.
- [obs] designates terminology that is identified as obsolete in *ICD-O-3.2*.
- * WHO revised preferred terminology for these neoplasms and no longer requires “malignant” to be used in order to code behavior of /3 (1/1/2024 +).

-A-

Acidophil adenocarcinoma
Acidophil carcinoma
Acinar adenocarcinoma
Acinar adenocarcinoma, sarcomatoid (C61.9)
Acinar carcinoma
Acinar cell carcinoma
Acinar cell cystadenocarcinoma
Acinic cell adenocarcinoma
Acquired cystic disease-associated renal cell carcinoma (RCC) (C64.9)
Acral lentiginous melanoma, malignant

ACTH-producing tumor
Acute basophilic leukemia
Acute bilineal leukemia
Acute biphenotypic leukemia
Acute differentiated progressive histiocytosis
(See acute progressive histiocytosis X)
Acute erythremia [obs]
Acute erythremic myelosis [obs]
Acute erythroid leukemia
Acute granulocytic leukemia, minimal differentiation
Acute granulocytic leukemia *(FAB or WHO type not specified)*
Acute granulocytic leukemia with maturation
Acute granulocytic leukemia without maturation
Acute leukemia, Burkitt type [obs]
Acute leukemia, NOS
Acute lymphatic leukemia
Acute lymphatic leukemia, L1 type
Acute lymphatic leukemia, L2 type
Acute lymphoblastic leukemia, Burkitt type
Acute lymphoblastic leukemia, L1 type, NOS
Acute lymphoblastic leukemia, L2 type, NOS
Acute lymphoblastic leukemia, mature B-cell type
Acute lymphoblastic leukemia, NOS
Acute lymphoblastic leukemia, precursor-cell type
Acute lymphoblastic leukemia-lymphoma, NOS
Acute lymphocytic leukemia
Acute lymphocytic leukemia, L1 type
Acute lymphocytic leukemia, L2 type
Acute lymphoid leukemia
Acute lymphoid leukemia, L1 type
Acute lymphoid leukemia, L2 type
Acute megakaryoblastic leukemia
Acute mixed lineage leukemia
Acute monoblastic leukemia
Acute monocytic leukemia
Acute myeloblastic leukemia, minimal differentiation
Acute myeloblastic leukemia
Acute myeloblastic leukemia with maturation
Acute myeloblastic leukemia without maturation
Acute myelocytic leukemia, minimal differentiation
Acute myelocytic leukemia *(FAB or WHO type not specified)*
Acute myelocytic leukemia with maturation
Acute myelocytic leukemia without maturation
Acute myelofibrosis
Acute myelogenous leukemia, minimal differentiation
Acute myelogenous leukemia *(FAB or WHO type not specified)*
Acute myelogenous leukemia with maturation
Acute myelogenous leukemia without maturation
Acute myeloid leukemia (megakaryoblastic) with t(1;22)(p13;q13); RBM15-MKL1
Acute myeloid leukemia, minimal differentiation
Acute myeloid leukemia, NOS
Acute myeloid leukemia with abnormal marrow eosinophils (includes all variants)
Acute myeloid leukemia with BCR-ABL1
Acute myeloid leukemia with biallelic mutations of CEBPA
Acute myeloid leukemia with inv(3)(q21;q26.2) or t(3;3)(q21;q26.2); RPN1EVI1
Acute myeloid leukemia with maturation
Acute myeloid leukemia with multilineage dysplasia
Acute myeloid leukemia with mutated NPM1
Acute myeloid leukemia with mutated RUNX1
Acute myeloid leukemia with prior myelodysplastic syndrome
Acute myeloid leukemia with t(6;9)(p23;q34) DEK-NUP214
Acute myeloid leukemia without maturation
Acute myeloid leukemia without prior myelodysplastic syndrome
Acute myeloid leukemia, 11q23 abnormalities
Acute myeloid leukemia, AML1(CBF-alpha)/ETO
Acute myeloid leukemia, CBF-beta/MYH11
Acute myeloid leukemia, inv(16)(p13;q22)
Acute myeloid leukemia, M6 type
Acute myeloid leukemia, MLL
Acute myeloid leukemia, PML/RAR-alpha
Acute myeloid leukemia, t(8;21)(q22;q22)
Acute myeloid leukemia, t(15;17)(q22;q11-12)
Acute myeloid leukemia, t(16;16)(p13;q11)
Acute myelomonocytic leukemia, NOS
Acute myelomonocytic leukemia with abnormal eosinophils
Acute myelosclerosis
Acute non-lymphocytic leukemia
Acute panmyelosis, NOS [obs]
Acute panmyelosis with myelofibrosis
Acute progressive histiocytosis X
Acute promyelocytic leukemia, NOS
Acute promyelocytic leukemia, PML/RAR-alpha
Acute promyelocytic leukemia, t(15;17)(q22;q11-12)
Adamantinoma, malignant
Adamantinoma of long bones
Adenoacanthoma
Adenocarcinoid tumor
Adenocarcinoma admixed with neuroendocrine carcinoma (C53._)
Adenocarcinoma combined with other types of carcinoma
Adenocarcinoma, cylindroid
Adenocarcinoma, diffuse type
Adenocarcinoma, endocervical type
Adenocarcinoma, HPV-associated (C530-C531,C538-C539, 2021+)
Adenocarcinoma, HPV-independent, clear cell type (C53_ 2021+)
Adenocarcinoma, HPV-independent, endometrioid type (C53_ 2021+)
Adenocarcinoma, HPV-independent, gastric type (C53_ 2021+)
Adenocarcinoma, HPV-independent, mesonephric type(C53_ 2021+)
Adenocarcinoma, HPV-independent, NOS (C530-C531, C538-C539 2021+
Adenocarcinoma in a polyp, NOS
Adenocarcinoma in adenomatous polyp
Adenocarcinoma in adenomatous polyposis coli
Adenocarcinoma in multiple adenomatous polyps
Adenocarcinoma in polypoid adenoma
Adenocarcinoma in situ in a polyp, NOS
Adenocarcinoma in situ in adenomatous polyp
Adenocarcinoma in situ in polypoid adenoma
Adenocarcinoma in situ in tubular adenoma
Adenocarcinoma in situ in tubulovillous adenoma
Adenocarcinoma in situ in villous adenoma

Adenocarcinoma in situ, mucinous (C34._)
Adenocarcinoma in situ, non-mucinous (C34._)
Adenocarcinoma in situ, NOS
Adenocarcinoma in tubular adenoma
Adenocarcinoma in tubulovillous adenoma
Adenocarcinoma in villous adenoma
Adenocarcinoma, intestinal type
Adenocarcinoma, NOS
Adenocarcinoma of anal ducts
Adenocarcinoma of anal glands
Adenocarcinoma of rete ovarii (C56.9)
Adenocarcinoma, pancreatobiliary-type (C24.1)
Adenocarcinoma with apocrine metaplasia
Adenocarcinoma with cartilaginous and osseous metaplasia
Adenocarcinoma with cartilaginous metaplasia
Adenocarcinoma with mixed subtypes
Adenocarcinoma with neuroendocrine differentiation
Adenocarcinoma with osseous metaplasia
Adenocarcinoma with spindle cell metaplasia
Adenocarcinoma with squamous metaplasia
Adenocystic carcinoma
Adenoid basal carcinoma
Adenoid cystic carcinoma
Adenoid cystic (basal cell) carcinoma
Adenoid cystic carcinoma with high-grade transformation
Adenoid squamous cell carcinoma
Adenoma-like adenocarcinoma
Adenomatous polyp, high grade dysplasia (C160-C166, C168-C169, C170-C173, C178-C179 for 2022+ diagnosis only)
Adenomyoepithelioma with carcinoma (C50._)
Adenosarcoma
Adenosquamous carcinoma
Adnexal carcinoma
Adrenal cortical adenocarcinoma
Adrenal cortical carcinoma
Adrenal cortical tumor, malignant
Adrenal medullary paraganglioma (74.1)
Adrenal medullary paraganglioma, malignant
Adult T-cell leukemia
Adult T-cell leukemia/lymphoma
Adult T-cell leukemia/lymphoma (HTLV-1 positive) (includes all variants)
Adult T-cell lymphoma
Adult T-cell lymphoma/leukemia
Aggressive digital papillary adenoma (C44. _)
Aggressive NK-cell leukemia
Agnogenic myeloid metaplasia
AIDS-associated Kaposi sarcoma
AIN III
Aleukemic granulocytic leukemia [obs]
Aleukemic leukemia, NOS [obs]
Aleukemic lymphatic leukemia [obs]
Aleukemic lymphocytic leukemia [obs]
Aleukemic lymphoid leukemia [obs]
Aleukemic monocytic leukemia [obs]
Aleukemic myelogenous leukemia [obs]
Aleukemic myeloid leukemia [obs]
ALK positive large B-cell lymphoma
Alpha cell tumor, malignant
Alpha heavy chain disease
Alveolar adenocarcinoma
Alveolar carcinoma
Alveolar cell carcinoma
Alveolar rhabdomyosarcoma
Alveolar soft part sarcoma
Amelanotic melanoma
Ameloblastic carcinoma
Ameloblastic fibrodentinosarcoma
Ameloblastic fibro-odontosarcoma
Ameloblastic fibrosarcoma
Ameloblastic odontosarcoma
Ameloblastic sarcoma
Ameloblastoma, malignant
AML M6
Anal intraepithelial neoplasia, grade III
Anaplastic astrocytoma, IDH-mutant (C71._)
Anaplastic astrocytoma, IDH-wildtype (C71._)
Anaplastic large B-cell lymphoma
Anaplastic large cell lymphoma ALK-negative
Anaplastic large cell lymphoma ALK-negative Breast implant-associated anaplastic large cell lymphoma
Anaplastic large cell lymphoma (ALCL), CD 30+
Anaplastic large cell lymphoma, NOS
Anaplastic large cell lymphoma, T cell and Null cell type
Anaplastic oligoastrocytoma
Anaplastic oligodendroglioma, IDH-mutant and 1p/19q-codeleted (C71._)
Anaplastic pleomorphic xanthroastrocytoma (C71._)
Androblastoma, malignant
Angiocentric T-cell lymphoma [obs]
Angioendotheliomatosis
Angioimmunoblastic lymphoma [obs]
Angioimmunoblastic T-cell lymphoma
Angiomyosarcoma
Angiosarcoma
Angiotropic lymphoma
Aortic body tumor (C75.5)
Aortic body paraganglioma (75.5)
Aorticopulmonary paraganglioma (C75.5)
Appendiceal mucinous neoplasm with extra-appendiceal spread
Apocrine adenocarcinoma
Argentaffinoma, malignant [obs]
Arrhenoblastoma, malignant
Askin tumor
Astroblastoma
Astroblastoma, MN1-altered
Astrocytic glioma
Astrocytoma, anaplastic
Astrocytoma, IDH-mutant, grade 2
Astrocytoma, IDH-mutant, grade 3
Astrocytoma, IDH-mutant, grade 4
Astrocytoma, low grade
Astrocytoma, NOS
Astroglioma [obs]
Atypical carcinoid tumor
Atypical chronic myeloid leukemia, BCR/ABL negative
Atypical chronic myeloid leukemia, Philadelphia chromosome (Ph1) negative
Atypical hyperplasia/endometrioid intraepithelial neoplasm (C54._, C55.9)
Atypical medullary carcinoma
Atypical teratoid/rhabdoid tumor

-B-

B lymphoblastic leukemia/lymphoma, NOS
B lymphoblastic leukemia/lymphoma with hyperdiploidy
B lymphoblastic leukemia/lymphoma with hypodiploidy (hypodiploid ALL)
B lymphoblastic leukemia/lymphoma with t(1;19)(q23;p13.3); E2A PBX1 (TCF3 PBX1)
B lymphoblastic leukemia/lymphoma with t(5;14)(q31;q32); IL3-IGH
B lymphoblastic leukemia/lymphoma with t(9;22)(q34;q11.2); BCR-ABL1
B lymphoblastic leukemia/lymphoma with t(12;21)(p13;q22); TEL-AML1 (ETV6-RUNX1)
B lymphoblastic leukemia/lymphoma with t(v;11q23); MLL rearranged
B-ALL [obs]
Balloon cell melanoma
BALT lymphoma
Basal cell adenocarcinoma
Basaloid carcinoma
Basaloid squamous cell carcinoma
Basophil adenocarcinoma
Basophil carcinoma
Basophilic leukemia
B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma
B-cell lymphoma, NOS
~~Bednar tumor (C44._)~~2024+
Bellini duct carcinoma
Beta cell adenoma (C25.4)
Beta cell tumor, malignant
Bile duct adenocarcinoma
Bile duct carcinoma
Bile duct cystadenocarcinoma
Biphenotypic sinonasal sarcoma (C30.0, C31.0-C31.3, C31.8, C31.9)
Blast cell leukemia
Blastoma, NOS
Blue nevus, malignant
B-lymphocytic leukemia/lymphoma, BCR-ABL1-like
Botryoid sarcoma
Breast implant-associated anaplastic large cell lymphoma
Brenner tumor, malignant
Bronchial adenoma, carcinoid
Bronchial adenoma, cylindroid [obs]
Bronchial-associated lymphoid tissue lymphoma
Bronchiolar adenocarcinoma
Bronchiolar carcinoma
Bronchiolo-alveolar adenocarcinoma, NOS
Bronchiolo-alveolar carcinoma, NOS
Bronchiolo-alveolar carcinoma, Clara cell
Bronchiolo-alveolar carcinoma, Clara cell and goblet cell type
Bronchiolo-alveolar carcinoma, goblet cell type
Bronchiolo-alveolar carcinoma, indeterminate type
Bronchiolo-alveolar carcinoma, mixed mucinous and non-mucinous
Bronchiolo-alveolar carcinoma, mucinous
Bronchiolo-alveolar carcinoma, non-mucinous
Bronchiolo-alveolar carcinoma, type II pneumocyte
Bronchiolo-alveolar carcinoma, type II pneumocyte and goblet cell type
Burkitt cell leukemia
Burkitt-like lymphoma
Burkitt lymphoma, NOS
Burkitt tumor [obs]

-C-

C cell carcinoma
C-ALL
Cancer
Carcinofibroma
Carcinoid, NOS
Carcinoid tumor, argentaffin, malignant
Carcinoid tumor, NOS
Carcinoma, anaplastic, NOS
Carcinoma, diffuse type
Carcinoma in a polyp, NOS
Carcinoma in adenomatous polyp
Carcinoma in pleomorphic adenoma
Carcinoma in situ in a polyp, NOS
Carcinoma in situ in adenomatous polyp
Carcinoma in situ, NOS
Carcinoma, intestinal type
Carcinoma, NOS
Carcinoma showing thymus-like differentiation
Carcinoma showing thymus-like element
Carcinoma simplex
Carcinoma, undifferentiated, NOS
Carcinoma with apocrine metaplasia
Carcinoma with chondroid differentiation (C50._)
Carcinoma with neuroendocrine differentiation
Carcinoma with osseous differentiation (C50._)
Carcinoma with osteoclast-like giant cells
Carcinoma with other types mesenchymal differentiation (C50._)
Carcinoma with productive fibrosis
Carcinoma with sarcomatoid component
Carcinosarcoma, embryonal
Carcinosarcoma, NOS
Carotid body paraganglioma (C75.4)
Carotid body tumor (C75.4)
Cauda equina neuroendocrine tumor (cranial and paraspinal nerves)
CASTLE
Cellular ependymoma
Central neuroblastoma
Central osteosarcoma
Central primitive neuroectodermal tumor, NOS
Cerebellar sarcoma, NOS [obs]
Ceruminous adenocarcinoma
Ceruminous carcinoma
Chemodectoma
Chloroma
Cholangiocarcinoma
Chondroblastic osteosarcoma
Chondroblastoma, malignant
Chondroid chordoma
Chondrosarcoma, grade 1 (2022 +)
Chondrosarcoma grade II/III (grade 2/3)
Chondrosarcoma, NOS
Chordoma, NOS
Choriocarcinoma combined with embryonal carcinoma
Choriocarcinoma combined with other germ cell elements
Choriocarcinoma combined with teratoma
Choriocarcinoma, NOS

Chorioepithelioma
Chorionepithelioma
Choroid plexus carcinoma
Choroid plexus papilloma, anaplastic
Choroid plexus papilloma, malignant
Chromaffin paraganglioma (C74.1)
Chromaffinoma
Chromaffin tumor
Chromophobe adenocarcinoma
Chromophobe carcinoma
Chromophobe cell renal carcinoma
Chronic eosinophilic leukemia
Chronic erythremia [obs]
Chronic granulocytic leukemia
Chronic granulocytic leukemia, BCR/ABL
Chronic granulocytic leukemia, Philadelphia chromosome (Ph1) positive
Chronic granulocytic leukemia, t(9;22)(q34;q11)
Chronic idiopathic myelofibrosis
Chronic leukemia, NOS [obs]
Chronic lymphatic leukemia
Chronic lymphocytic leukemia
Chronic lymphocytic leukemia, B-cell type (includes all variants of BCLL)
Chronic lymphoid leukemia
Chronic lymphoproliferative disorder of NK-cells
Chronic monocytic leukemia [obs]
Chronic myelocytic leukemia
Chronic myelogenous leukemia, BCR/ABL positive
Chronic myelogenous leukemia, Philadelphia chromosome (Ph1) positive
Chronic myelogenous leukemia, t(9;22)(q34;q11)
Chronic myelogenous leukemia
Chronic myeloid leukemia
Chronic myelomonocytic leukemia in transformation [obs]
Chronic myelomonocytic leukemia, NOS
Chronic myelomonocytic leukemia, Type I
Chronic myelomonocytic leukemia, Type 2
Chronic myeloproliferative disease, NOS
Chronic myeloproliferative disorder
Chronic neutrophilic leukemia
CIC-rearranged sarcoma
Circumscribed arachnoidal cerebellar sarcoma [obs]
Classic epithelioid sarcoma
Classic indolent Kaposi sarcoma
Classical Hodgkin lymphoma, lymphocyte depletion, diffuse fibrosis
Classical Hodgkin lymphoma, lymphocyte depletion, NOS
Classical Hodgkin lymphoma, lymphocyte depletion, reticular
Classical Hodgkin lymphoma, lymphocyte-rich
Classical Hodgkin lymphoma, mixed cellularity, NOS
Classical Hodgkin lymphoma, nodular sclerosis, cellular phase
Classical Hodgkin lymphoma, nodular sclerosis, grade 1
Classical Hodgkin lymphoma, nodular sclerosis, grade 2
Classical Hodgkin lymphoma, nodular sclerosis, NOS
Clear cell adenocarcinofibroma
Clear cell adenocarcinoma, mesonephroid
Clear cell adenocarcinoma, NOS
Clear cell carcinoma
Clear cell chondrosarcoma
Clear cell cystadenocarcinofibroma
Clear cell ependymoma
Clear cell (glycogen-rich) urothelial carcinoma (C65.9, C66.9, C67._, C68._)
Clear cell neuroendocrine tumor, non-functioning pancreatic
Clear cell odontogenic carcinoma (C41.0, C41.1)
Clear cell sarcoma, NOS
Clear cell sarcoma of kidney
Clear cell sarcoma, of tendons and aponeuroses
Cloacogenic carcinoma
CNS embryonal tumor, NEC/NOS
CNS embryonal tumor with rhabdoid features (C71._)
CNS tumor with BCCR internal tandem duplication
CNS neuroblastoma, FOXR2-activated
Collecting duct carcinoma
Colloid adenocarcinoma
Colloid carcinoma
Combined carcinoid and adenocarcinoma
Combined hepatocellular carcinoma and cholangiocarcinoma
Combined large cell neuroendocrine carcinoma (C34._, C37.9)
Combined small cell carcinoma
Combined small cell-adenocarcinoma
Combined small cell-large cell carcinoma
Combined small cell-squamous cell carcinoma
Comedocarcinoma, noninfiltrating
Comedocarcinoma, NOS
Common ALL
Common precursor B ALL
Composite carcinoid
Composite Hodgkin and non-Hodgkin lymphoma
Composite paraganglioma
Composite pheochromocytoma (C74.1)
Condylomatous carcinoma
Congenital fibrosarcoma
Congenital spindle cell rhabdomyosarcoma with VGLL2/NCOA2/CITED2 rearrangements
Conventional urothelial carcinoma
Conventional central osteosarcoma
Cortical T ALL
CPEN
CPNET
Cribriform carcinoma, NOS
Cribriform carcinoma in situ
Cutaneous lymphoma, NOS [obs]
Cutaneous T-cell lymphoma, NOS
Cylindrical cell carcinoma
Cylindroma, NOS (except Cylindroma of skin M-8200/0)
Cystadenocarcinoma, NOS
Cyst-associated renal cell carcinoma
Cystic astrocytoma [obs]
Cystic hypersecretory carcinoma
Cystic neuroendocrine tumor, non-functioning pancreatic
Cystic pancreatic endocrine neoplasm (CPEN)
Cystosarcoma phyllodes, malignant

-D-

DCIS, comedo type
DCIS, NOS
DCIS of low nuclear grade
DCIS of intermediate nuclear grade

DCIS of high nuclear grade
DCIS, papillary
Dedifferentiated chondrosarcoma
Dedifferentiated chordoma
Dedifferentiated liposarcoma
Dendritic cell sarcoma, NOS
~~Dermatofibrosarcoma, NOS~~ (C44. _) 2021+
~~Dermatofibrosarcoma protuberans, NOS~~ (C44. _) 2021+
Dermatofibrosarcoma protuberans with myoid differentiation
Dermoid cyst with malignant transformation
Dermoid cyst with secondary tumor
Desmoplastic medulloblastoma
Desmoplastic melanoma, amelanotic
Desmoplastic melanoma, malignant
Desmoplastic mesothelioma
Desmoplastic nodular medulloblastoma
Desmoplastic small round cell tumor
Di Guglielmo disease [obs]
Differentiated penile intraepithelial neoplasia (C60._)
Differentiated-type vulvar intraepithelial neoplasia (C51._)
Diffuse astrocytoma
Diffuse astrocytoma, IDH-mutant (C71._)
Diffuse astrocytoma, IDH-wildtype (C71._)
Diffuse astrocytoma, low grade
Diffuse astrocytoma, MYB- or MYBL1-altered (1/1/2023+, behavior /3)
Diffuse embryoma
Diffuse hemispheric glioma, H3 G34-mutant
Diffuse leptomeningeal glioneuronal tumor (1/1/2023+)
Diffuse large B-cell lymphoma associated with chronic inflammation of the pleura (C384)
Diffuse low-grade glioma, MAPK pathway-altered (1/1/2023+, behavior /3)
Diffuse midline glioma, H3 K27M-mutant (altered) (C71._)
Diffuse pediatric-type glioma, H3-wildtype and IDH-wildtype
Diffuse pleural mesothelioma (C384)
Diffuse pulmonary lymphangiomatosis (C34_)
Digital papillary adenocarcinoma
Diktyoma, malignant
DIN 3
Duct adenocarcinoma, NOS
Duct carcinoma, desmoplastic type
Duct carcinoma, NOS
Duct cell carcinoma
Ductal carcinoma, NOS
Ductal carcinoma in situ, comedo type
Ductal carcinoma in situ, cribriform type
Ductal carcinoma in situ, micropapillary
Ductal carcinoma in situ, NOS
Ductal carcinoma in situ, papillary
Ductal carcinoma in situ, solid type
Ductal carcinoma, cribriform type
Ductal intraepithelial neoplasia 3
Dysgerminoma

-E-

EC cell carcinoid
Eccrine adenocarcinoma
Eccrine papillary adenocarcinoma
Eccrine poroma, malignant
ECL cell carcinoid, malignant
Ectomesenchymoma
ELOC (formerly TCEB1) mutated RCC (C649)
Embryoma
Embryonal adenocarcinoma
Embryonal carcinoma, infantile
Embryonal carcinoma, NOS
Embryonal carcinoma, polyembryonal type
Embryonal hepatoma
Embryonal rhabdomyosarcoma, NOS
Embryonal rhabdomyosarcoma, pleomorphic
Embryonal sarcoma
Embryonal teratoma
Embryonal tumor with multilayered rosettes C19MC-altered (C71._)
Embryonal tumor with multilayered rosettes, NOS (C71._)
Embryonal tumor with rhabdoid features (C71._)
Encapsulated follicular variant of papillary thyroid carcinoma, NOS (EFVPTC, NOS) (C73.9)
Encapsulated papillary carcinoma (C50._)
Encapsulated papillary carcinoma with invasion (C50._)
Endemic African Kaposi sarcoma
Endemic Burkitt Lymphoma
Endocervical adenocarcinoma usual type (C53._)
Endocrine tumor, functioning, NOS
Endodermal sinus tumor
Endolymphatic stromal myosis
Endometrial sarcoma, NOS
Endometrial stromal sarcoma, NOS
Endometrial stromal sarcoma, high grade
Endometrial stromal sarcoma, low grade
Endometrial stromatosis
Endometrioid adenocarcinoma, NOS
Endometrioid adenocarcinoma, ciliated cell variant
Endometrioid adenocarcinoma, secretory variant
Endometrioid adenocarcinoma, villoglandular (C54._, C55.9)
Endometrioid carcinoma with squamous differentiation (C54._, C55.9)
Endometrioid adenofibroma, malignant
Endometrioid carcinoma, NOS
Endometrioid cystadenocarcinoma
Endometrioid cystadenofibroma, malignant
Endometrioid intraepithelial neoplasia (C54.1)
Enteric adenocarcinoma (C34.0, C67._, C65.9, C66.9, C68._)
Enterochromaffin cell carcinoid
Enterochromaffin-like cell tumor, malignant
Enteroglucagonoma, malignant
Enteropathy associated T-cell lymphoma
Enteropathy type intestinal T-cell lymphoma
Eosinophil adenocarcinoma
Eosinophil carcinoma
Eosinophilic leukemia
Eosinophilic solid and cystic RCC (C649)
Ependymoblastoma
Ependymoma, anaplastic
Ependymoma, NOS
Ependymoma, RELA fusion-positive (C71._)
Epidermoid carcinoma in situ, NOS

Epidermoid carcinoma in situ with questionable stromal invasion
Epidermoid carcinoma, keratinizing
Epidermoid carcinoma, large cell, nonkeratinizing
Epidermoid carcinoma, NOS
Epidermoid carcinoma, small cell, nonkeratinizing
Epidermoid carcinoma, spindle cell
Epithelial ependymoma
Epithelial tumor, malignant
Epithelial-myoepithelial carcinoma
Epithelioid angiosarcoma
Epithelioid cell melanoma
Epithelioid cell sarcoma
Epithelioid glioblastoma (C71._)
Epithelioid hemangioendothelioma
Epithelioid hemangioendothelioma, malignant
Epithelioid hemangioendothelioma with WWTR1-CAMTA1 fusion
Epithelioid hemangioendothelioma with YAP1-TFE3 fusion
Epithelioid leiomyosarcoma
Epithelioid malignant peripheral nerve sheath tumor (C47.0–C47.6, C47.8, C47.9)
Epithelioid mesothelioma, malignant
Epithelioid mesothelioma, NOS
Epithelioid MPNST
Epithelioid myxofibrosarcoma
Epithelioid sarcoma
Epithelioma, malignant
Epithelioma, NOS
Erdhiem-Chester Disease
Erythremic myelosis, NOS [obs]
Erythroleukemia
Essential hemorrhagic thrombocythemia
Essential thrombocythemia
Esthesioneuroblastoma
Esthesioneurocytoma
Esthesioneuroepithelioma
Ewing sarcoma
Ewing tumor
Extra-adrenal paraganglioma, malignant
Extra-adrenal paraganglioma, NOS
Extramedullary plasmacytoma

-F-

FAB L1 [obs]
FAB L2
FAB L3 [obs]
FAB M0
FAB M1
FAB M2, AML1(CBF-alpha)/ETO
FAB M2, NOS
FAB M2, t(8;21)(q22;q22)
FAB M3 (includes all variants)
FAB M4
FAB M4Eo (replaced *ICD-O-2*'s FAB M4E in *ICD-O-3*)
FAB M5 (includes all variants) (replaced *ICD-O-2*'s entries for FAB M5A and FAB M5B in *ICD-O-3)*
FAB M6
FAB M7
Fascial fibrosarcoma
Fetal adenocarcinoma
Fibrillary astrocytoma
Fibrin-associated diffuse B-cell lymphoma (C380)
Fibroblastic liposarcoma
Fibroblastic osteosarcoma
Fibroblastic reticular cell tumor
Fibrochondrosarcoma
Fibroepithelial basal cell carcinoma, Pinkus type
Fibroepithelioma of Pinkus type
Fibroepithelioma, NOS
Fibroliposarcoma
Fibromatosis-like metaplastic carcinoma (C50._)
Fibromyxosarcoma
Fibrosarcoma, NOS
Fibrosarcomatous dermatofibrosarcoma protuberans
Fibrous astrocytoma
Fibrous histiocytoma, malignant
Fibrous mesothelioma, malignant
Fibrous mesothelioma, NOS
Fibroxanthoma, malignant
Florid lobular carcinoma in situ
Follicular adenocarcinoma, moderately differentiated
Follicular adenocarcinoma, NOS
Follicular adenocarcinoma, trabecular
Follicular adenocarcinoma, well differentiated
~~Follicular carcinoma, encapsulated~~ (C73.9) 2021+
Follicular carcinoma, minimally invasive
Follicular carcinoma, moderately differentiated
Follicular carcinoma, NOS
Follicular carcinoma, oxyphilic cell
Follicular carcinoma, trabecular
Follicular carcinoma, well differentiated
Follicular dendritic cell sarcoma
Follicular dendritic cell tumor
Follicular thyroid carcinoma (FTC), encapsulated angioinvasive (C73.9)
~~Follicular tumor of uncertain malignant potential~~ (C73.9) 2021+
Franklin disease
Fumarate hydratase-deficient RCC ALK-rearranged RCC (C649)

-G-

G cell tumor, malignant
Gamma heavy chain disease
Ganglioglioma, anaplastic
Ganglioneuroblastoma
GANT
Gastrin cell tumor, malignant
Gastroblastoma (C160-C169)
Gastrinoma *
Gastrinoma, malignant
Gastrointestinal autonomic nerve tumor
Gastrointestinal pacemaker cell tumor
Gastrointestinal stromal sarcoma
Gastrointestinal stromal tumor, malignant
Gelatinous adenocarcinoma [obs]
Gelatinous carcinoma [obs]
Gemistocytic astrocytoma
Gemistocytoma
Germ cell tumor, nonseminomatous
Germ cell tumor, NOS
Germ cell tumors with associated hematological malignancy (C37.9)
Germinoma

Ghost cell odontogenic carcinoma (C41.0, C41.1)
Giant cell and spindle cell carcinoma
Giant cell carcinoma
Giant cell glioblastoma
Giant cell sarcoma
Giant cell sarcoma of bone
Giant cell tumor of bone, malignant
Giant cell tumor of tendon sheath, malignant
GIST, malignant
Glandular intraepithelial neoplasia, grade III
Glassy cell carcinoma
Glioblastoma, IDH-mutant (C71._)
Glioblastoma, IDH-wildtype (C71._)
Glioblastoma multiforme
Glioblastoma, NOS
Glioblastoma with sarcomatous component
Glioma, malignant
Glioma, NOS
Gliomatosis cerebri
Gliosarcoma
Glomangiosarcoma
Glomoid sarcoma
Glomus jugulare tumor, NOS (C75.5)
Glomus tumor, malignant
Glucagonoma *
Glucagonoma, malignant
Glycogen-rich carcinoma
Goblet cell adenocarcinoma
Goblet cell carcinoid
Granular cell adenocarcinoma
Granular cell carcinoma
Granular cell myoblastoma, malignant
Granular cell tumor, malignant
Granulocytic leukemia, NOS
Granulocytic sarcoma
Granulosa cell carcinoma
Granulosa cell tumor, adult type (C56.9)
Granulosa cell tumor, malignant
Granulosa cell tumor, sarcomatoid
Grawitz tumor [obs]
Guglielmo disease

-H-

Hairy cell leukemia
Hairy cell leukemia variant
Heavy chain disease, NOS
Hemangioendothelial sarcoma
Hemangioendothelioma, malignant
Hemangiopericytoma, malignant
Hemangiosarcoma
Hepatoblastoma
Hepatocarcinoma
Hepatocellular carcinoma, clear cell type
Hepatocellular carcinoma, chromophobe
Hepatocellular carcinoma, fibrolamellar
Hepatocellular carcinoma, lymphocyte-rich
Hepatocellular carcinoma, macrotrabecular massive
Hepatocelluar carcinoma, neutrophil-rich
Hepatocellular carcinoma, NOS
Hepatocellular carcinoma, pleomorphic type
Hepatocellular carcinoma, sarcomatoid
Hepatocellular carcinoma, scirrhous
Hepatocellular carcinoma, spindle cell variant
Hepatocellular carcinoma, steatohepatic
Hepatocholangiocarcinoma
Hepatoid adenocarcinoma
Hepatoid carcinoma
Hepatoid yolk sac tumor
Hepatoma, malignant
Hepatoma, NOS
Hepatosplenic (gamma-delta) lymphoma
Hereditary leiomyomatosis & RCC-associated renal cell carcinoma (C64.9)
Hidradenocarcinoma
High-grade appendiceal mucinous neoplasm (HAMN) C181
High-grade astrocytoma with piloid features (HGAP) 01/01/2023+, behavior /3
High-grade neuroendocrine carcinoma (C54._, C55.9)
High-grade serous carcinoma (C48._, C56.9, C57.0, C57.1-C57.3)
High-grade surface osteosarcoma
Histiocyte-rich large B-cell lymphoma
Histiocytic medullary reticulosis [obs]
Histiocytic sarcoma
Hodgkin disease, lymphocyte depletion, diffuse fibrosis
Hodgkin disease, lymphocyte depletion, NOS
Hodgkin disease, lymphocyte depletion, reticular
Hodgkin disease, lymphocyte predominance, diffuse [obs]
Hodgkin disease, lymphocyte predominance, nodular
Hodgkin disease, lymphocyte predominance, NOS [obs]
Hodgkin disease, lymphocytic-histiocytic predominance [obs]
Hodgkin disease, mixed cellularity, NOS
Hodgkin disease, nodular sclerosis, cellular phase
Hodgkin disease, nodular sclerosis, lymphocyte depletion
Hodgkin disease, nodular sclerosis, lymphocyte predominance
Hodgkin disease, nodular sclerosis, mixed cellularity
Hodgkin disease, nodular sclerosis, NOS
Hodgkin disease, nodular sclerosis, syncytial variant
Hodgkin disease, NOS
Hodgkin granuloma [obs]
Hodgkin lymphoma, lymphocyte depletion, diffuse fibrosis
Hodgkin lymphoma, lymphocyte depletion, NOS
Hodgkin lymphoma, lymphocyte depletion, reticular
Hodgkin lymphoma, lymphocyte predominance, nodular
Hodgkin lymphoma, lymphocyte-rich
Hodgkin lymphoma, mixed cellularity, NOS
Hodgkin lymphoma, nodular lymphocyte predominance
Hodgkin lymphoma, nodular sclerosis, cellular phase
Hodgkin lymphoma, nodular sclerosis, grade 1
Hodgkin lymphoma, nodular sclerosis, grade 2
Hodgkin lymphoma, nodular sclerosis, NOS
Hodgkin lymphoma, NOS
Hodgkin paragranuloma, nodular [obs]
Hodgkin paragranuloma, NOS [obs]
Hodgkin sarcoma [obs]
Hurthle cell adenocarcinoma
Hurthle cell carcinoma
Hutchinson melanotic freckle, NOS
Hyalinizing clear cell carcinoma
~~Hydroa vacciniforme-like lymphoproliferative disorder (lymphoma)~~2021+

Hypereosinophilic syndrome
Hypernephroma [obs]

-I-

Iatrogenic Kaposi sarcoma
Idiopathic hemorrhagic thrombocythemia
Idiopathic thrombocythemia
Immature teratoma, malignant
Immature teratoma, NOS
~~Immature teratoma of the lung~~ (C34. _) 2021+
~~Immature teratoma of thymus~~ (C37.9) 2021+
~~Immature teratoma of thyroid~~ (C73.9) 2021+
Immunoblastic sarcoma [obs]
Immunocytoma [obs]
Immunodeficiency-associated Burkitt Lymphoma
Immunoproliferative disease, NOS
Immunoproliferative small intestinal disease
Infant-type hemispheric glioma
Infantile fibrosarcoma
Infiltrating and papillary adenocarcinoma
Infiltrating duct adenocarcinoma
Infiltrating duct and colloid carcinoma
Infiltrating duct and cribriform carcinoma
Infiltrating duct and lobular carcinoma
Infiltrating duct and lobular carcinoma in situ
Infiltrating duct and mucinous carcinoma
Infiltrating duct and tubular carcinoma
Infiltrating duct carcinoma, NOS
Infiltrating duct mixed with other types of carcinoma
Infiltrating ductular carcinoma
Infiltrating lobular carcinoma
Infiltrating lobular carcinoma and ductal carcinoma in situ
Infiltrating lobular mixed with other types of carcinoma
Infiltrating papillary adenocarcinoma
Inflammatory adenocarcinoma
Inflammatory carcinoma
Inflammatory liposarcoma
Insular carcinoma
Insulinoma, malignant
Insulinoma, NOS (C25.4) *
Interdigitating cell sarcoma
Interdigitating dendritic cell sarcoma
Interstitial cell tumor, malignant
Intestinal T-cell lymphoma
Intestinal-type adenoma, high grade (C160-C166, C168-C169 ,C170-C173, C178-C179 for 2022+ dx years only)
Intestinal-type adenocarcinoma (C30.0, C53._)
Intimal sarcoma
Intracortical osteosarcoma
Intracystic carcinoma, NOS
Intracystic papillary adenocarcinoma
Intracystic papillary neoplasm with associated invasive carcinoma
Intraductal adenocarcinoma, noninfiltrating, NOS
Intraductal and lobular carcinoma
Intraductal carcinoma and lobular carcinoma in situ
Intraductal carcinoma, clinging
Intraductal carcinoma, noninfiltrating, NOS
Intraductal carcinoma, NOS
Intraductal carcinoma, solid type
Intraductal micropapillary carcinoma
Intraductal oncocytic papillary neoplasm, NOS (C250-C254, C257-C259)
Intraductal oncocytic papillary neoplasm with associated invasive carcinoma (C250-C254, C257-C259)
Intraductal papillary adenocarcinoma, NOS
Intraductal papillary adenocarcinoma with invasion
Intraductal papillary carcinoma, NOS
Intraductal papillary-mucinous carcinoma, invasive
Intraductal papillary-mucinous carcinoma, non-invasive
Intraductal papillary mucinous neoplasm (IPMN) with an associated invasive carcinoma (C25._)
Intraductal papillary mucinous neoplasm with high-grade dysplasia (C25._)
Intraductal papilloma with ductal carcinoma in situ (C50._)
Intraductal papilloma with lobular carcinoma in situ (C50._)
Intraductal tubulopapillary neoplasm (C25._)
Intraepidermal carcinoma, NOS
Intraepithelial carcinoma, NOS
Intraepithelial neoplasia, grade III, of vulva or vagina
Intraepithelial squamous cell carcinoma
Intraosseous carcinoma
Intraosseous low grade osteosarcoma
Intraosseous spindle cell rhabdomyosarcoma with TFCP2/NCOA2 rearrangements
Intraosseous well differentiated osteosarcoma
Intrapulmonary thymoma (C34._) *
Intratubular embryonal carcinoma
Intratubular germ cell neoplasia
Intratubular malignant germ cells
Intratubular seminoma
Intratubular teratoma
Intratubular trophoblast
Intratubular yolk-sac tumor
Intravascular B-cell lymphoma
Intravascular bronchial alveolar tumor [obs]
Intravascular large B-cell lymphoma
Invasive carcinoma of no special type (C50._)
Invasive carcinoma, NST (C50._)
Invasive encapsulated follicular variant of papillary thyroid carcinoma (invasive EFVPTC) (C73.9)
Invasive lobular carcinoma (C50._)
Invasive lobular carcinoma, alveolar type (C50._)
Invasive lobular carcinoma, solid type (C50._)
Invasive lobular carcinoma, tubulolobular variant (C50._)
Invasive mammary carcinoma (C50._)
Invasive micropapillary carcinoma (C50._)
Invasive mucinous adenocarcinoma (C34._)
Islet cell adenocarcinoma
Islet cell adenoma (C25.4)
Islet cell adenomatosis (C25.4)
Islet cell carcinoma
Islet cell tumor, NOS (C25.4)

-J-

Jugular paraganglioma C75.5)
Jugulotympanic paraganglioma (C75.5)
Juvenile astrocytoma (reportable as behavior 3 in North America)
Juvenile carcinoma of breast
Juvenile chronic myelomonocytic leukemia
Juvenile myelomonocytic leukemia
Juvenile xanthogranuloma (C715)
Juxtacortical chondrosarcoma

Juxtacortical osteogenic sarcoma [obs] (see Juxtacortical osteosarcoma)
Juxtacortical osteosarcoma

-K-

Kaposi sarcoma
Klatskin tumor
Krukenberg tumor (/6)
Kupffer cell sarcoma

-L-

Langerhans cell histiocytosis (LCH), disseminated
Langerhans cell histiocytosis (LCH), generalized
~~Langerhans cell histiocytosis, mono-ostotic~~ 2021+
~~Langerhans cell histiocytosis, NOS~~ 2021+
~~Langerhans cell histiocytosis, poly-ostotic~~ 2021+
Langerhans cell sarcoma
Large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease
Large cell (Ki-1+) lymphoma [obs]
Large cell carcinoma, NOS
Large cell carcinoma with rhabdoid phenotype
Large cell medulloblastoma
Large cell neuroendocrine carcinoma
Large nested urothelial carcinoma
Laryngeal intraepithelial neoplasia, grade III (LINIII)
Laryngeal paraganglioma
LCH disseminated LCIS, NOS
LCH generalized
Leiomyosarcoma, NOS
Lennert lymphoma
Lentigo maligna
Lentigo maligna melanoma
Lepidic adenocarcinoma (C34._)
Lepidic predominant adenocarcinoma (C34._)
Leptomeningeal sarcoma
Letterer-Siwe disease
Leukemia, NOS
Leukemic reticuloendotheliosis
Leydig cell tumor, malignant
LINIII
Linitis plastica
Lipid-rich carcinoma
Lipid-rich urothelial carcinoma (C65.9, C66.9, C67._, C68._)
Lipoma-like liposarcoma
Liposarcoma, differentiated
Liposarcoma, NOS
Liposarcoma, well differentiated
Liver cell carcinoma
Lobular adenocarcinoma
Lobular and ductal carcinoma
Lobular carcinoma in situ, NOS
Lobular carcinoma, noninfiltrating
Lobular carcinoma, NOS
Localized pleural mesothelioma (C384)
Low-grade adenosquamous carcinoma (C50._)
Low-grade appendiceal mucinous neoplasm (LAMN) C181
Low-grade cribriform cystadenocarcinoma (LGCCC) (C06.9, C08.9)
Low-grade central osteosarcoma (C40._, C41._)
Low-grade fibromyxoid sarcoma
Low-grade intramedullary osteosarcoma (C40._, C41._)
Low-grade myofibroblastic sarcoma (C01.9, C02._, C06.9, C49._)
Low-grade papillary adenocarcinoma (C34_)
Low-grade papillary urothelial carcinoma with an inverted growth pattern
Low-grade serous carcinoma (C48._, C56.9, C57.0, C57.1–C57.3)
Lymphangioendothelioma, malignant
Lymphangioendothelial sarcoma
Lymphangioleiomyomatosis (behavior /3; 1/1/2023+)
Lymphangiosarcoma
Lymphatic leukemia, NOS [obs]
Lymphoblastic leukemia, L1 type
Lymphoblastic leukemia, L2 type
Lymphoblastic leukemia, NOS
Lymphoblastoma [obs]
Lymphocytic leukemia, NOS [obs]
Lymphoepithelial carcinoma
Lymphoepithelioid lymphoma
Lymphoepithelioma
Lymphoepithelioma-like carcinoma
Lymphoid leukemia, NOS
Lymphoma, NOS
Lymphomatoid granulomatosis, grade 3
~~Lymphoid papulosis~~ (C44. _)2021+
Lymphosarcoma cell leukemia [obs]
Lymphosarcoma, diffuse [obs]
Lymphosarcoma, NOS [obs]

-M-

M6A
M6B
Malignancy
Malignant chondroid syringoma
Malignant cystic nephroma
Malignant eccrine spiradenoma
Malignant fibrous histiocytoma
Malignant fibrous histiocytoma (MFH) of bone
Malignant giant cell tumor of soft parts
Malignant histiocytosis
Malignant lymphoma, centroblastic, diffuse
Malignant lymphoma, centroblastic, follicular
Malignant lymphoma, centroblastic, NOS
Malignant lymphoma, centroblastic-centrocytic, diffuse [obs]
Malignant lymphoma, centroblastic-centrocytic, follicular [obs]
Malignant lymphoma, centroblastic-centrocytic NOS [obs]
Malignant lymphoma, centrocytic [obs]
Malignant lymphoma, cleaved cell, NOS [obs]
Malignant lymphoma, convoluted cell [obs]
Malignant lymphoma, diffuse, NOS
Malignant lymphoma, follicle center, follicular
Malignant lymphoma, follicle center, NOS
Malignant lymphoma, follicular, grade 1
Malignant lymphoma, follicular, grade 2
Malignant lymphoma, follicular, grade 3
Malignant lymphoma, follicular, NOS
Malignant lymphoma, histiocytic, diffuse
Malignant lymphoma, histiocytic, nodular [obs]
Malignant lymphoma, histiocytic, NOS [obs]

Malignant lymphoma, Hodgkin
Malignant lymphoma, immunoblastic, NOS
Malignant lymphoma, large B-cell, diffuse, centroblastic, NOS
Malignant lymphoma, large B-cell, diffuse, immunoblastic, NOS
Malignant lymphoma, large B-cell, diffuse, NOS
Malignant lymphoma, large B-cell, NOS
Malignant lymphoma, large cell, cleaved and noncleaved [obs]
Malignant lymphoma, large cell, cleaved, diffuse
Malignant lymphoma, large cell, cleaved, NOS [obs]
Malignant lymphoma, large cell, diffuse, NOS [obs]
Malignant lymphoma, large cell, follicular, NOS
Malignant lymphoma, large cell, immunoblastic
Malignant lymphoma, large cell, noncleaved, diffuse, NOS [obs]
Malignant lymphoma, large cell, noncleaved, NOS
Malignant lymphoma, large cell, noncleaved, follicular [obs]
Malignant lymphoma, large cell, noncleaved, NOS
Malignant lymphoma, large cell, NOS
Malignant lymphoma, large cleaved cell, follicular [obs]
Malignant lymphoma, large cleaved cell, NOS [obs]
Malignant lymphoma, lymphoblastic, NOS
Malignant lymphoma, lymphocytic, diffuse, NOS
Malignant lymphoma, lymphocytic, intermediate differentiation, diffuse [obs]
Malignant lymphoma, lymphocytic, intermediate differentiation, nodular [obs]
Malignant lymphoma, lymphocytic, nodular, NOS [obs]
Malignant lymphoma, lymphocytic, NOS
Malignant lymphoma, lymphocytic, poorly differentiated, diffuse [obs]
Malignant lymphoma, lymphocytic, poorly differentiated, nodular [obs]
Malignant lymphoma, lymphocytic, well differentiated, diffuse
Malignant lymphoma, lymphocytic, well differentiated, nodular [obs]
Malignant lymphoma, lymphoplasmacytic
Malignant lymphoma, lymphoplasmacytoid
Malignant lymphoma, mixed cell type, diffuse [obs]
Malignant lymphoma, mixed cell type, follicular [obs]
Malignant lymphoma, mixed cell type, nodular [obs]
Malignant lymphoma, mixed lymphocytic-histiocytic, diffuse [obs]
Malignant lymphoma, mixed lymphocytic-histiocytic, nodular [obs]
Malignant lymphoma, mixed small and large cell, diffuse [obs]
Malignant lymphoma, mixed small cleaved and large cell, follicular [obs]
Malignant lymphoma, nodular, NOS [obs]
Malignant lymphoma, non-Hodgkin, NOS
Malignant lymphoma, non-cleaved, diffuse, NOS [obs]
Malignant lymphoma, non-cleaved, follicular, NOS [obs]
Malignant lymphoma, non-cleaved, NOS
Malignant lymphoma, non-cleaved cell, NOS
Malignant lymphoma, NOS
Malignant lymphoma, plasmacytoid [obs]
Malignant lymphoma, small B lymphocytic, NOS
Malignant lymphoma, small cell diffuse
Malignant lymphoma, small cell, noncleaved, diffuse [obs]
Malignant lymphoma, small cell, NOS
Malignant lymphoma, small cleaved cell, diffuse [obs]
Malignant lymphoma, small cleaved cell, follicular [obs]
Malignant lymphoma, small cleaved cell, NOS [obs]
Malignant lymphoma, small lymphocytic, diffuse
Malignant lymphoma, small lymphocytic, NOS
Malignant lymphoma, small noncleaved, Burkitt type [obs]
Malignant lymphoma, undifferentiated, Burkitt type [obs]
Malignant lymphoma, undifferentiated cell, non-Burkitt [obs]
Malignant lymphoma, undifferentiated cell type, NOS [obs]
Malignant lymphomatous polyposis [obs]
Malignant mast cell tumor
Malignant mastocytoma
Malignant mastocytosis
Malignant melanoma in congenital melanocytic nevus
Malignant melanoma in giant pigmented nevus
Malignant melanoma in Hutchinson melanotic freckle
Malignant melanoma in junctional nevus
Malignant melanoma in precancerous melanosis
Malignant melanoma, NOS
Malignant melanoma, regressing
Malignant melanotic nerve sheath tumor
Malignant midline reticulosis [obs]
Malignant mucinous adenofibroma
Malignant mucinous cystadenofibroma
Malignant multilocular cystic nephroma
Malignant myelosclerosis [obs]
Malignant myoepithelioma
Malignant peripheral nerve sheath tumor
Malignant peripheral nerve sheath tumor with rhabdomyoblastic differentiation
Malignant perivascular epithelial cell tumor
Malignant reticulosis, NOS [obs]
Malignant rhabdoid tumor
Malignant Schwannoma, NOS [obs]
Malignant Schwannoma with rhabdomyoblastic differentiation
Malignant serous adenofibroma
Malignant serous cystadenofibroma
Malignant tenosynovial giant cell tumor
Malignant teratoma, anaplastic
Malignant teratoma, intermediate
Malignant teratoma, trophoblastic
Malignant teratoma, undifferentiated
Malignant tumor, clear cell type
Malignant tumor, fusiform cell type
Malignant tumor, giant cell type
Malignant tumor, small cell type
Malignant tumor, spindle cell type
MALT lymphoma
MALT lymphoma of the dura
Mammary carcinoma, in situ (C50._)
Mantle cell lymphoma
Mantle zone lymphoma [obs]
Marginal zone B-cell lymphoma, NOS
Marginal zone lymphoma, NOS
Mast cell leukemia
Mast cell sarcoma
Mature T ALL

Mature T-cell lymphoma, NOS
Mature teratoma of the testes in adults
MCN of the pancreas with high-grade dysplasia
Mediastinal large B-cell lymphoma
Mediterranean lymphoma
Medullary adenocarcinoma
Medullary carcinoma, NOS
Medullary carcinoma with amyloid stroma
Medullary carcinoma with lymphoid stroma
Medullary osteosarcoma
Medullary thyroid carcinoma (C73.9)
Medulloblastoma, classic
Medulloblastoma, group 3 (C71._)
Medulloblastoma, group 4 (C71._)
Medulloblastoma, histologically defined (C716)
Medulloblastoma, non-WNT/non-SHH (C71._)
Medulloblastoma, NOS
Medulloblastoma, SHH-activated and TP53-mutant (C71._)
Medulloblastoma, SHH-activated and TP53-wildtype (C71._)
Medulloblastoma, WNT-activated (C71._)
Medulloepithelioma, NOS
Medullomyoblastoma
Megakaryoblastic leukemia, NOS
Megakaryocytic leukemia
Megakaryocytic myelosclerosis
Melanoma in situ
Melanoma, malignant, of soft parts
Melanoma, NOS
Melanotic medulloblastoma
Melanotic MPNST
Melanotic psammomatous MPNST
Meningeal melanoma (C70._, C71._)
Meningeal melanomatosis
Meningeal sarcoma
Meningeal sarcomatosis
Meningioma, anaplastic
Meningioma, malignant
Meningothelial sarcoma
Merkel cell carcinoma
Merkel cell tumor
Mesenchymal chondrosarcoma
Mesenchymal tumor, malignant
Mesenchymoma, malignant
Mesodermal mixed tumor
Mesonephric adenocarcinoma
Mesonephric-like adenocarcinoma
Mesonephroma, malignant
Mesonephroma, NOS
Mesothelioma, biphasic, malignant
Mesothelioma, biphasic, NOS
Mesothelioma, in situ (C384) (behavior /2; 1/1/2023+)
Mesothelioma, malignant
Mesothelioma, NOS
Metaplastic carcinoma, NOS
Metaplastic carcinoma of no special type (C50._)
Metaplastic carcinoma with chondroid differentiation (C50._)
Metaplastic carcinoma with osseous differentiation (C50._)
Metaplastic carcinoma with other types mesenchymal differentiation (C50._)
Metaplastic Thymoma (C37.9) *
Microcystic adnexal carcinoma
Microcystic urothelial carcinoma (C65.9, C66.9, C67._, C68._)
Microglioma [obs]
Micropapillary adenocarcinoma (C34._)
Micropapillary carcinoma, NOS (C18._, C19.9, C20.9, C34._)
Micropapillary serous carcinoma
Middle ear paraganglioma (C30.1, C75.5))
Midline carcinoma of children and young adults with NUT rearrangement (C30.0, C31.9, C34._)
Minimally invasive adenocarcinoma, mucinous (C34._)
Minimally invasive adenocarcinoma, non-mucinous (C34._)
Minimally invasive adenocarcinoma, NOS (C34._)
MiT family translocation renal cell carcinoma (C64.9)
Mixed acidophil-basophil carcinoma
Mixed acinar ductal carcinoma
Mixed acinar-endocrine carcinoma
Mixed adenocarcinoma and epidermoid carcinoma
Mixed adenocarcinoma and squamous cell carcinoma
Mixed carcinoid-adenocarcinoma
Mixed cell adenocarcinoma
Mixed ductal-endocrine carcinoma
Mixed embryonal carcinoma and teratoma
Mixed embryonal rhabdomyosarcoma and alveolar rhabdomyosarcoma
Mixed epithelioid and spindle cell melanoma
Mixed germ cell tumor
Mixed glioma
Mixed hepatocellular and bile duct carcinoma
Mixed invasive mucinous and non-mucinous adenocarcinoma (C34._)
Mixed islet cell and exocrine adenocarcinoma
Mixed liposarcoma
Mixed medullary-follicular carcinoma
Mixed medullary-papillary carcinoma
Mixed mesenchymal sarcoma
Mixed oligoastrocytoma (see Oligoastrocytoma)
Mixed phenotype acute leukemia, B/myeloid, NOS
Mixed phenotype acute leukemia, T/myeloid, NOS
Mixed phenotype acute leukemia with t(9;22)(q34;q11.2); BCR-ABL1
Mixed phenotype acute leukemia with t(v;11q23); MLL rearranged
Mixed pineal tumor
Mixed pineocytoma-pineoblastoma
Mixed small cell carcinoma
Mixed teratoma and seminoma
Mixed teratoma and yolk-sac tumor
Mixed tumor, malignant, NOS
Mixed tumor, salivary gland type, malignant
Mixed type rhabdomyosarcoma
Monoblastic leukemia, NOS
Monocytic leukemia, NOS
Monocytoid B-cell lymphoma
Monstrocellular sarcoma [obs]
MPNST with glandular differentiation
MPNST with mesenchymal differentiation
MPNST with rhabdomyoblastic differentiation
MPNST, NOS
Mu heavy chain disease
Mucin-producing adenocarcinoma
Mucin-producing carcinoma

Mucin-secreting adenocarcinoma
Mucin-secreting carcinoma
Mucinous adenocarcinofibroma
Mucinous adenocarcinoma
Mucinous adenocarcinoma, endocervical type
Mucinous carcinoid
Mucinous carcinoma
Mucinous carcinoma, gastric type (C53._)
Mucinous carcinoma, intestinal type (C53._)
Mucinous cystadenocarcinofibroma
Mucinous cystadenocarcinoma, non-invasive
Mucinous cystadenocarcinoma, NOS
Mucinous cystic neoplasm (MCN) (non-invasive) of the pancreas with high-grade dysplasia
Mucinous cystic tumor with associated invasive carcinoma (C25._)
Mucinous tubular and spindle cell carcinoma (C64.9)
Mucocarcinoid tumor
Mucoepidermoid carcinoma
Mucoid adenocarcinoma
Mucoid carcinoma
Mucoid cell adenocarcinoma
Mucosal-associated lymphoid tissue (MALT) lymphoma
Mucosal lentiginous melanoma
Mucous adenocarcinoma
Mucous carcinoma
Mullerian adenosarcoma (C54._, C55.9)
Mullerian mixed tumor
Multinodular and vascolating neuronal tumor (MVNT) (C71.2) (1/1/2023+ new code)
Multiple hemorrhagic sarcoma
Multiple myeloma
Mycosis fungoides
Myelocytic leukemia, NOS
Myelodysplastic/Myeloproliferative neoplasm, unclassifiable
Myelodysplastic syndrome, NOS
Myelodysplastic syndrome with 5q deletion (5q-) syndrome
Myelodysplastic syndrome with ring sideroblasts and multilineage dysplasia
Myelofibrosis as a result of myeloproliferative disease
Myelofibrosis with myeloid metaplasia
Myelogenous leukemia, NOS
Myeloid and lymphoid neoplasm with FGFR1 abnormalities
Myeloid and lymphoid neoplasms with PDGFRA rearrangement
Myeloid leukemia associated with Down Syndrome
Myeloid leukemia, NOS
Myeloid/lymphoid neoplasms with PCM1-JAK2
Myeloid neoplasms with PDGFRB rearrangement
Myeloid sarcoma
Myeloma, NOS
Myelomatosis
Myelomonocytic leukemia, NOS
Myeloproliferative neoplasm, unclassifiable
Myelosclerosis with myeloid metaplasia
MYOD1-mutant spindle cell/sclerosing rhabdomyosarcoma
Myoepithelial carcinoma
Myofibroblastic sarcoma
Myosarcoma
Myxoid chondrosarcoma
Myxoid glioneuronal tumor
Myxoid leiomyosarcoma
Myxoid liposarcoma
Myxoid pleomorphic liposarcoma
Myxoliposarcoma
Myxosarcoma

-N-

Neoplasm, malignant
Nephroblastoma, NOS
Nephroma, NOS
Nesidioblastoma (C25.4)
Nested urothelial carcinoma (C65.9, C66.9, C67._, C68._)
Neurilemmoma, malignant [obs]
Neurilemmosarcoma [obs]
Neuroblastoma, NOS
Neuroectodermal tumor, NOS
Neuroendocrine carcinoma, NOS
Neuroendocrine carcinoma, poorly differentiated (C50._)
Neuroendocrine tumor, well differentiated (C50._)
Neuroepithelioma, NOS
Neurofibrosarcoma [obs]
Neurogenic sarcoma [obs]
Neurosarcoma [obs]
Neurotropic melanoma, malignant
NK/T-cell lymphoma, nasal and nasal-type
Nodal marginal zone lymphoma
Nodular hidradenoma, malignant
Nodular melanoma
Non-Hodgkin lymphoma, NOS
Nonchromaffin paraganglioma, malignant
Nonchromaffin paraganglioma, NOS
Nonencapsulated sclerosing adenocarcinoma
Nonencapsulated sclerosing carcinoma
Nonencapsulated sclerosing tumor
Noninfiltrating intracystic carcinoma
Noninfiltrating intraductal papillary adenocarcinoma
Noninfiltrating intraductal papillary carcinoma
Non-invasive EFVPTC (C73.9)
Non-invasive encapsulated follicular variant of papillary thyroid carcinoma (non-invasive EFVPTC) (C73.9)
~~Non-invasive follicular thyroid neoplasm with papillary-like nuclear features (NIFTP) (C73.9)~~ 2021+
Non-invasive high-grade papillary urothelial carcinoma with an inverted growth pattern
Non-invasive papillary urothelial carcinoma, high-grade
Non-invasive papillary urothelial carcinoma, low-grade
Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high-grade dysplasia
~~Non-invasive FTP (C73.9)~~ 2021+
Non-invasive low-grade serous carcinoma (C56.9)
Non-invasive mammary carcinoma (C50._)
Nonlipid reticuloendotheliosis [obs]
Non-lymphocytic leukemia, NOS
Non-small cell carcinoma
NTRK-rearranged spindle cell neoplasm (emerging)
NUT carcinoma (C30.0, C31.9, C34._)
NUT midline (C30.0, C31.9, C34._)

-O-

Oat cell carcinoma
Odontogenic carcinoma

Odontogenic carcinosarcoma
Odontogenic fibrosarcoma
Odontogenic sarcoma
Odontogenic tumor, malignant
Olfactory neuroblastoma
Olfactory neuroepithelioma
Olfactory neurogenic tumor
Olfactory neurocytoma
Oligoastrocytoma
Oligoastrocytoma, NOS (C71._)
Oligodendroblastoma [obs]
Oligodendroglioma, anaplastic
Oligodendroglioma, IDH-mutant and 1p/19q-codeleted (C71._)
Oligodendroglioma, IDH-mutant and 1p/19q-codeleted, grade 2 (C71._)
Oligodendroglioma, IDH-mutant and 1p/19q-codeleted, grade 3 (C71._)
Oligodendroglioma, NOS
Oncocytic adenocarcinoma
Oncocytic carcinoma
Oncocytic neuroendocrine tumor, non-functioning pancreatic
Orchioblastoma
Ossifying fibromyxoid tumor, malignant (C49._)
Osteoblastic sarcoma
Osteochondrosarcoma
Osteoclastoma, malignant
Osteofibrosarcoma
Osteogenic sarcoma, NOS
Osteosarcoma in Paget disease of bone
Osteosarcoma, NOS
Oxyphilic adenocarcinoma

-P-

Paget disease and infiltrating duct carcinoma of breast
Paget disease and intraductal carcinoma of breast
Paget disease, extramammary
Paget disease, mammary
Paget disease of breast
Pagetoid reticulosis
Pancreatic endocrine tumor, NOS (C25.4)
Pancreatobiliary-type carcinoma (C24.1)
Pancreatoblastoma
Paneth cell carcinoma
Papillary adenocarcinoma, follicular variant
Papillary adenocarcinoma, NOS
Papillary and follicular adenocarcinoma
Papillary and follicular carcinoma
Papillary carcinoma, columnar cell
Papillary carcinoma, diffuse sclerosing
Papillary carcinoma, encapsulated
Papillary carcinoma, follicular variant
Papillary carcinoma in situ
Papillary carcinoma, NOS
Papillary carcinoma of thyroid
Papillary carcinoma, oxyphilic cell
Papillary carcinoma, tall cell
Papillary cystadenocarcinoma, NOS
Papillary ependymoma
Papillary epidermoid carcinoma
Papillary neoplasm pancreaticobiliary type with high grade intraepithelial neoplasia (C241)
Papillary meningioma
Papillary microcarcinoma
Papillary mucinous cystadenocarcinoma
Papillary pseudomucinous cystadenocarcinoma
Papillary renal cell carcinoma
Papillary serous adenocarcinoma
Papillary serous cystadenocarcinoma
Papillary squamous cell carcinoma
Papillary squamous cell carcinoma in situ
Papillary squamous cell carcinoma, non-invasive
Papillary transitional cell carcinoma
Papillary transitional cell carcinoma, non-invasive
Papillary tumor of pineal region (C75.3)
Papillary urothelial carcinoma
Papillary urothelial carcinoma, non-invasive
Papillocystic adenocarcinoma
Papillotubular adenocarcinoma
Parafollicular cell carcinoma
Paraganglioma, malignant
Paraganglioma, NOS (C75.5) *
Parasympathetic paraganglioma (C75.5)
Parietal cell carcinoma
Parosteal osteosarcoma
PEComa, malignant
Periductal stromal tumor, low-grade (C50._)
Perineural MPNST
Perineurioma, malignant
Periosteal chondrosarcoma
Periosteal fibrosarcoma
Periosteal osteogenic sarcoma (see Periosteal osteosarcoma)
Periosteal osteosarcoma
Periosteal sarcoma, NOS
Peripheral neuroectodermal tumor
Peripheral primitive neuroectodermal tumor, NOS
Peripheral T-cell lymphoma, AILD (Angioimmunoblastic Lymphadenopathy with Dysproteinemia) [obs]
Peripheral T-cell lymphoma, large cell
Peripheral T-cell lymphoma, pleomorphic medium and large cell
Peripheral T-cell lymphoma, NOS
Peripheral T-cell lymphoma, pleomorphic small cell
Perivascular epithelioid cell tumor, malignant
Pheochromoblastoma
Pheochromocytoma, malignant
Pheochromocytoma, NOS (74.1) *
Phosphaturic mesenchymal tumor, malignant
Phyllodes tumor, malignant
~~Pigmented dermatofibrosarcoma protuberans~~ (C44._)2024+
Pilocytic astrocytoma (reportable as behavior 3 in North America unless primary site is optic nerve)
Piloid astrocytoma (reportable as behavior 3 in North America unless primary site is optic nerve)
Pilomyxoid astrocytoma (C71._)
Pineal parenchymal tumor of intermediate differentiation
Pineoblastoma
Pinkus tumor
Pituitary neuroendocrine tumor (PitNET) (C751) (behavior /3)
Pituitary blastoma
Pituitary carcinoma, NOS
Placental site trophoblastic tumor of testis (C62.0-C62.9 for dx 1/1/2024+ only)

Plaque-like dermatofibrosarcoma protuberans
Plasma cell leukemia
Plasma cell myeloma
Plasma cell tumor
Plasmablastic lymphoma
Plasmacytic leukemia
Plasmacytic lymphoma [obs]
Plasmacytoid urothelial carcinoma
Plasmacytoma, extramedullary (not occurring in bone)
Plasmacytoma, NOS
Plasmacytoma of bone
Pleomorphic carcinoma
Pleomorphic cell sarcoma
Pleomorphic liposarcoma
Pleomorphic lobular carcinoma (C50._)
Pleomorphic lobular carcinoma in situ (C50._)
Pleomorphic neuroendocrine tumor, non-functioning pancreatic
Pleomorphic rhabdomyosarcoma, NOS
Pleomorphic rhabdomyosarcoma, adult type
Pleomorphic xanthoastrocytoma
Pleuropulmonary blastoma
PNET, NOS
Pneumoblastoma
Polar spongioblastoma
Polycythemia rubra vera
Polycythemia vera
Polyembryoma
Polygonal cell carcinoma
Post Transplant Lymphoproliferative Disorder (PTLD) 2021+ (2025+ reportable)
Polymorphous low-grade neuroepithelial tumor of the young
Polymorphic reticulosis [obs]
Polymorphous low grade adenocarcinoma
Polyvesicular vitelline tumor
Poorly differentiated urothelial carcinoma
Porocarcinoma
Post radiation angiosarcoma of the breast
Posterior fossa ependymoma, NOS
Posterior fossa group A (PFA) ependymoma
Posterior fossa group B (PFB) ependymoma
PPNET
Pre-B ALL
Precancerous melanosis, NOS
Precursor B-cell lymphoblastic leukemia
Precursor B-cell lymphoblastic lymphoma
Precursor cell lymphoblastic leukemia, NOS
Precursor cell lymphoblastic leukemia, not phenotyped
Precursor cell lymphoblastic lymphoma, NOS
Precursor T-cell lymphoblastic leukemia
Precursor T-cell lymphoblastic lymphoma
Preleukemia [obs]
Preleukemic syndrome [obs]
Pre-pre-B ALL
Pre-T ALL
Primary cutaneous anaplastic large cell lymphoma
Primary cutaneous CD30+ large T-cell lymphoma
~~Primary cutaneous CD30+ T cell lymphoproliferative disorder~~ (C44. _) 2021+
~~Primary cutaneous CD4 positive small/medium T-cell lymphoma~~ (C44. _) 2021+
Primary cutaneous follicle centre lymphoma
Primary cutaneous gamma-delta T-cell lymphoma
Primary cutaneous neuroendocrine carcinoma
Primary effusion lymphoma
Primary intracranial sarcoma, DICER1-mutant
Primary intraosseous carcinoma
Primary serous papillary carcinoma of peritoneum
Primitive neuroectodermal tumor, NOS
Primitive polar spongioblastoma [obs]
Pro-B ALL
Proliferative polycythemia
Prolymphocytic leukemia, B-cell type
Prolymphocytic leukemia, NOS
Prolymphocytic leukemia, T-cell type
Prostatic intraepithelial-like carcinoma (C619)
Pro-T ALL
Protoplasmic astrocytoma
Proximal or large cell epithelioid sarcoma
Pseudoglandular squamous cell carcinoma
Pseudomucinous adenocarcinoma
Pseudomucinous cystadenocarcinoma, NOS
Pseudomyxoma peritonei with unknown primary site
Pseudosarcomatous carcinoma
Pulmonary artery intimal sarcoma
Pulmonary blastoma
Pulmonary myxoid sarcoma with EWSR1-CREB1 translocation (C34._)
Pure squamous carcinoma of urothelial tract

-Q-

Queyrat erythroplasia

-R-

RAEB
RAEB I
RAEB II
RAEB-T
RARS
Refractory anemia, NOS
Refractory anemia with excess blasts
Refractory anemia with excess blasts in transformation [obs]
Refractory anemia with ringed sideroblasts
Refractory anemia with sideroblasts
Refractory anemia without sideroblasts
Refractory cytopenia with multilineage dysplasia
Refractory neutropenia
Refractory thrombocytopenia
Renal carcinoma, collecting duct type
Renal cell adenocarcinoma
Renal cell carcinoma, NOS
Renal cell carcinoma, chromophobe cell
Renal cell carcinoma, chromophobe type
Renal cell carcinoma, sarcomatoid
Renal cell carcinoma, spindle cell
Renal cell carcinoma, unclassified (C64.9)
Renal medullary carcinoma (C64.9)
Reserve cell carcinoma
Reticulosarcoma, diffuse [obs]
Reticulosarcoma, NOS [obs]
Reticulum cell sarcoma, diffuse [obs]
Reticulum cell sarcoma, NOS [obs]
Retinoblastoma, differentiated
Retinoblastoma, diffuse
Retinoblastoma, NOS

Retinoblastoma, undifferentiated
Rhabdoid meningioma
Rhabdoid sarcoma
Rhabdoid tumor, NOS
Rhabdomyosarcoma, NOS
Rhabdomyosarcoma with ganglionic differentiation
Rhabdosarcoma
Rosai-Dorfman disease
Round cell carcinoma
Round cell liposarcoma
Round cell osteosarcoma
Round cell sarcoma
Round cell sarcoma with EWSR1-non-ETS fusions

-S-

Salivary duct carcinoma (C06.9, C08.9)
SALT lymphoma
Sarcoma botryoides
Sarcoma, NOS
Sarcoma with BCOR genetic alterations
Sarcomatoid carcinoma
Sarcomatoid mesothelioma
Schminke tumor
Schneiderian carcinoma
Scirrhous adenocarcinoma
Scirrhous carcinoma
Sclerosing epithelioid fibrosarcoma
Sclerosing liposarcoma
Sclerosing hepatic carcinoma
Sclerosing rhabdomyosarcoma
Sclerosing sweat duct carcinoma
Sclerosing thymoma (C34._) *
Sebaceous adenocarcinoma
Sebaceous carcinoma
Secretory carcinoma of breast
Seminoma, anaplastic
Seminoma, NOS
Seminoma with high mitotic index
Seminoma with syncytiotrophoblastic cells
Seromucinous carcinoma (C56.9)
Serotonin producing carcinoid
Serous adenocarcinofibroma
Serous adenocarcinoma, NOS
Serous carcinoma, NOS
Serous cystadenocarcinofibroma
Serous cystadenocarcinoma, NOS
Serous endometrial intraepithelial carcinoma (C54._, C55.9)
Serous surface papillary carcinoma
Serous tubal intraepithelial carcinoma (C57.0)
Serrated adenocarcinoma (C18.0, C18.2, C18.9, C19.9, C20.9)
Serrated dysplasia, high grade (C160-C166, C168-C169, C170-C173, C178-C179 for 2022+ diagnosis only)
Sertoli cell carcinoma
Sertoli-Leydig cell tumor, poorly differentiated
Sertoli-Leydig cell tumor, poorly differentiated, with heterologous elements
Sertoli-Leydig cell tumor, sarcomatoid
SETTLE
Sezary disease
Sezary syndrome
Signet ring cell adenocarcinoma
Signet ring cell carcinoma
SINIII, except cervix and skin
Skin appendage carcinoma
Skin-associated lymphoid tissue lymphoma
Small cell carcinoma, fusiform cell
Small cell carcinoma, intermediate cell
Small cell carcinoma, large cell variant (C56.9)
Small cell carcinoma, NOS
Small cell carcinoma, hypercalcemic type (C56.9)
Small cell carcinoma pulmonary type (C56.9)
Small cell osteosarcoma
Small cell sarcoma
Small cell-large cell carcinoma
Small cell neuroendocrine carcinoma
SMARCB1-deficient dedifferentiated RCC of other specific subtypes (C649)
SMARCB1-deficient medullary-like RCC (C649)
SMARCB1-deficient undifferentiated RCC NOS (C649)
Soft tissue sarcoma
Soft tissue tumor, malignant
Solid adenocarcinoma with mucin formation
Solid carcinoma, NOS
Solid-basaloid adenoid cystic carcinoma
Solid carcinoma with mucin formation
Solid papillary carcinoma in situ (C50._)
Solid papillary carcinoma with invasion (C50._)
Solid pseudopapillary carcinoma
Solid pseudopapillary neoplasm of pancreas
Solitary fibrous tumor/hemangiopericytoma Grade 3 (CNS) (C71._)
Solitary fibrous tumor, malignant
Solitary myeloma
Solitary plasmacytoma
Somatostatin cell tumor, malignant
Somatostatinoma *
Somatostatinoma, malignant
Spermatocytic seminoma
Spermatocytic tumor with sarcomatous differentiation
Spermatocytoma
Spinal ependymoma, NOS (C720)
Spinal ependymoma, MYCN-amplified (C720)
Spindle cell carcinoma
Spindle cell melanoma, NOS
Spindle cell melanoma, type A
Spindle cell melanoma, type B
Spindle cell rhabdomyosarcoma
Spindle cell sarcoma
Spindle epithelial tumor with thymus-like differentiation
Spindle epithelial tumor with thymus-like element
Spindled mesothelioma
Splenic lymphoma with villous lymphocytes
Splenic marginal zone B-cell lymphoma
Splenic marginal zone lymphoma, NOS
Spongioblastoma multiforme
Spongioblastoma polare
Spongioneuroblastoma
Sporadic Burkitt Lymphoma
Squamotransitional cell carcinoma (C53._)
Squamous carcinoma
Squamous cell carcinoma, acantholytic
Squamous cell carcinoma, adenoid
Squamous cell carcinoma, clear cell type

Squamous cell carcinoma, HPV-associated (C53_ 2021+) (C60._; C63.2 beginning 1/1/2024)
Squamous cell carcinoma, HPV-independent (C53_ 2021+) C60._; C63.2 beginning 1/1/2024)
Squamous cell carcinoma, HPV-negative (C01.9, C09.9, C10.2, C10.3, C10.8, C10.9, C31.0–C31.3, C31.9
Squamous cell carcinoma, HPV-positive (C01.9, C09.9, C10.2, C10.3, C10.8, C10.9, C31.0–C31.3, C31.9)
Squamous cell carcinoma in situ, NOS
Squamous cell carcinoma in situ with questionable stromal invasion
Squamous cell carcinoma, keratinizing, NOS
Squamous cell carcinoma, large cell, keratinizing
Squamous cell carcinoma, large cell, nonkeratinizing, NOS
Squamous cell carcinoma, microinvasive
Squamous cell carcinoma, nonkeratinizing, NOS
Squamous cell carcinoma, NOS
Squamous cell carcinoma, pseudoglandular
Squamous cell carcinoma, sarcomatoid
Squamous cell carcinoma, small cell, nonkeratinizing
Squamous cell carcinoma, spindle cell
Squamous cell carcinoma with horn formation
Squamous cell epithelioma
Squamous intraepithelial neoplasia, grade II, except C53._ and skin
Squamous intraepithelial neoplasia, grade III (SINIII), except C53._ and skin
Stem cell leukemia
Steroid cell tumor, malignant
Stromal endometriosis
Stromal myosis, NOS
Stromal sarcoma, NOS
Struma ovarii, malignant
Subacute granulocytic leukemia [obs]
Subacute leukemia, NOS [obs]
Subacute lymphatic leukemia [obs]
Subacute lymphocytic leukemia [obs]
Subacute lymphoid leukemia [obs]
Subacute monocytic leukemia [obs]
Subacute myelogenous leukemia [obs]
Subacute myeloid leukemia [obs]
Subcutaneous panniculitic, T-cell lymphoma (See subcutaneous panniculitis-like T-cell lymphoma)
Subcutaneous panniculitis-like T-cell lymphoma
Superficial spreading adenocarcinoma
Superficial spreading melanoma
Supratentorial ependymoma, NOS
Supratentorial ependymoma, YAP1 fusion-positive
Supratentorial ependymoma, ZFTA fusion-positive
Supratentorial PNET
Sweat gland adenocarcinoma
Sweat gland carcinoma
Sweat gland tumor, malignant
Sympathicoblastoma
Synovial sarcoma, biphasic
Synovial sarcoma, epithelioid cell
Synovial sarcoma, monophasic fibrous
Synovial sarcoma, NOS
Synovial sarcoma, spindle cell
Synovioma, malignant
Synovioma, NOS
Syringomatous carcinoma
Systemic EBV positive T-cell lymphoproliferative disease of childhood
Systemic tissue mast cell disease

-T-

T(6;11)RCC (C649)
T lymphoblastic leukemia/lymphoma
T/NK-cell lymphoma
Tall cell carcinoma with reversed polarity
Tanycytic ependymoma
T-cell/histiocyte rich large B-cell lymphoma
T-cell large granular lymphocytic leukemia
T-cell lymphoma, NOS
T-cell rich B-cell lymphoma
T-cell rich large B-cell lymphoma
T-cell rich/histiocyte-rich large B-cell lymphoma
T-zone lymphoma
Telangiectatic osteosarcoma
Teratoblastoma, malignant
Teratocarcinoma
Teratoid medulloepithelioma
Teratoma, malignant, NOS
Teratoma, postpubertal-type
Teratoma with malignant transformation
Terminal duct adenocarcinoma
TFEB-altered RCC (C64.9)
TFEB-rearranged RCC (C64.9)
Thecoma, malignant
Therapy-related acute myeloid leukemia and myelodysplastic syndrome, NOS
Therapy-related acute myeloid leukemia, alkylating agent related
Therapy-related acute myeloid leukemia, epipodophyllotoxin-related
Therapy-related acute myeloid leukemia, NOS
Therapy-related myelodysplastic syndrome, alkylating agent related
Therapy-related myelodysplastic syndrome, epipodophyllotoxin-related
Therapy-related myelodysplastic syndrome, NOS
Thoracic SMARCA4-deficient undifferentiated tumor (C34_)
Thymic carcinoma, NOS
Thymic carcinoma with adenoid cystic carcinoma-like features (C37.9)
Thymic large B-cell lymphoma
Thymoma atypical (C37.9) *
Thymoma, atypical, malignant
Thymoma, cortical, malignant
Thymoma, epithelial (C37.9) *
Thymoma, epithelial, malignant
Thymoma, lymphocyte-rich, malignant
Thymoma, lymphocytic, malignant
Thymoma, malignant
Thymoma, medullary, malignant
Thymoma, mixed type, malignant
Thymoma, NOS (C37.9) *
Thymoma, organoid, malignant
Thymoma, predominantly cortical, malignant
Thymoma, spindle cell, malignant
Thymoma, type A, malignant
Thymoma, type AB, malignant
Thymoma, type B1, malignant

Thymoma, type B2, malignant
Thymoma, type B3, malignant
Thymoma, type C
Tibial adamantinoma
Trabecular adenocarcinoma
Trabecular carcinoma
Transitional carcinoma
Transitional cell carcinoma in situ
Transitional cell carcinoma, micropapillary
Transitional cell carcinoma, NOS
Transitional cell carcinoma, sarcomatoid
Transitional cell carcinoma, spindle cell
Transitional pineal tumor
Triton tumor, malignant
Trophoblastic tumor, epithelioid
True histiocytic lymphoma [obs]
Tubular adenocarcinoma
Tubular and microcystic urothelial carcinoma
Tubular carcinoma
Tubulocystic renal cell carcinoma (C64.9)
Tubulolobular carcinoma (C50._)
Tubulopapillary adenocarcinoma
Tumors cells, malignant
Tumor, malignant, NOS
Type A thymoma including atypical variant (C37.9) *
Type AB thymoma (C37.9) *
Type B1 thymoma (C37.9) *
Type B2 thymoma (C37.9) *
Type B3 thymoma (C37.9) *
Typical carcinoid
T-zone lymphoma

-U-

Unclassified tumor, malignant
Undifferentiated epithelioid sarcoma
Undifferentiated high-grade pleomorphic sarcoma
Undifferentiated leukemia
Undifferentiated pleomorphic sarcoma
Undifferentiated round cell sarcoma
Undifferentiated sarcoma
Undifferentiated spindle cell sarcoma
Undifferentiated uterine sarcoma
Urachal carcinoma (C65.9, C66.9, C67._, C68._)
Urothelial carcinoma
Urothelial carcinoma in situ
Urothelial carcinoma with divergent differentiation (C65.9, C66.9, C67._, C68._)
Urothelial carcinoma with squamous differentiation (C65.9, C66.9, C67._, C68._)
Urothelial carcinoma with trophoblastic differentiation (C65.9, C66.9, C67._, C68._)

-V-

Vagal paraganglioma
Vaginal intraepithelial neoplasia, grade III
VAIN, III
Verrucous carcinoma, NOS
Verrucous epidermoid carcinoma
Verrucous squamous cell carcinoma
Villoglandular carcinoma (C53._)
Villous adenocarcinoma
VIN, III
VIPoma *
Vipoma, malignant
Vulvar intraepithelial neoplasia, grade III

-W-

Waldenstrom macroglobulinemia
Warty carcinoma
Water-clear cell adenocarcinoma
Water-clear cell carcinoma
Well differentiated thymic carcinoma
Wilms tumor
Wolffian duct carcinoma
Wuchernde Struma Langhans [obs] (Deleted in *ICD-O-3*)

-XYZ-

Xp11 translocation RCC (C64.9)
Yolk sac tumor

B. REPORTABLE BENIGN AND BORDERLINE INTRACRANIAL AND CENTRAL NERVOUS SYSTEM TUMORS

-A-

Acidophil adenoma
Acoustic neuroma
Adamantinomatous craniopharyngioma
Adenoma, NOS
Adult cystic teratoma
Adult teratoma, NOS
Ancient schwannoma
Angioblastoma
Angiocentric glioma (C71._)
Angioendothelioma
Angiolipoma, NOS
Angioma, NOS
Angiomatous meningioma
Atypical choroid plexus papilloma
Atypical lipoma
Atypical meningioma

-B-

Basophil adenoma

-C-

Capillary hemangioma
Cavernous hemangioma
Cellular schwannoma
Central neurocytoma
Cerebellar liponeurocytoma
Chordoid glioma
Chordoid glioma of third ventricle
Chordoid meningioma
Choroid plexus papilloma, NOS
Chromophobe adenoma
Clear cell adenoma
Clear cell meningioma
Clear cell tumor, NOS
Craniopharyngioma
Cystic teratoma, NOS

-D-

Degenerated schwannoma
Dermoid cyst, NOS
Dermoid, NOS
Desmoplastic infantile astrocytoma
Desmoplastic infantile ganglioglioma
Diffuse leptomeningeal glioneuronal tumor (C71._)
Diffuse melanocytosis
Diffuse meningiomatosis
Dysembryoplastic neuroepithelial tumor
Dysplastic gangliocytoma of cerebellum (Lhermitte-Duclos)

-E-

Endotheliomatous meningioma
Eosinophil adenoma
Epithelial tumor, benign

-F-

Fibroblastic meningioma
Fibrolipoma
Fibroma, NOS
Fibromyoma
Fibrous meningioma

-G-

Gangliocytoma
Ganglioglioma, NOS
Ganglioneuroma
Glandular papilloma
Gliofibroma
Glioneuroma [obs]
Granular cell myoblastoma, NOS
Granular cell tumor of the sellar region
Granular cell tumor, NOS

-H-

Hemangioblastoma
Hemangioendothelioma, benign
Hemangioendothelioma, NOS
Hemangioma simplex
Hemangioma, NOS
Hemangiopericytic meningioma [obs]
Hemangiopericytoma, benign
Hemangiopericytoma, NOS

-I-

Infantile hemangioma
Intraneural perineurioma
Intravascular leiomyomatosis

-J-

Juvenile hemangioma

-K-

Kaposiform hemangioendothelioma

-L-

Leiomyofibroma
Leiomyoma, NOS
Leiomyomatosis, NOS
Lipoleiomyoma
Lipoma, NOS
Lipomatous medulloblastoma
Localized fibrous tumor
Lymphoplasmacyte-rich meningioma

-M-

Mature teratoma
Medullocytoma
Melanotic neurofibroma
Melanotic schwannoma
Meningeal melanocytoma
Meningioma, NOS
Meningiomatosis, NOS
Meningothelial meningioma
Metaplastic meningioma
Microcystic meningioma
Mixed acidophil-basophil adenoma
Mixed cell adenoma
Mixed meningioma
Mixed subependymoma-ependymoma
Monomorphic adenoma
Mucoid cell adenoma
Multiple meningiomas
Multiple neurofibromatosis
Myxopapillary ependymoma

-N-

Neoplasm, benign
Neoplasm, uncertain whether benign or malignant
Nerve sheath myxoma
Neurilemoma, NOS
Neurinoma
Neurinomatosis
Neuroastrocytoma [obs]
Neurocytoma
Neurofibroma, NOS
Neurofibromatosis, NOS
Neurolipocytoma
Neuroma, NOS
Neurothekeoma

-O-

Oncocytic adenoma
Oncocytoma
Oxyphilic adenoma

-P-

Papillary adenoma, NOS
Papillary craniopharyngioma
Papillary glioneuronal tumor (C71._)
Paraganglioma, NOS
Perineurioma, NOS
Pigmented schwannoma
Pilocytic/juvenile astrocytoma of optic nerve (C72.3)
Pinealoma, NOS
Pituicytoma (C75.1)
Pineocytoma
Pituitary adenoma, NOS
Plexiform hemangioma
Plexiform leiomyoma
Plexiform neurofibroma
Plexiform neuroma
Plexiform schwannoma
Prolactinoma
Psammomatous meningioma
Psammomatous schwannoma

-R-

Rathke pouch tumor
Recklinghausen disease
Rhabdomyoma, NOS
Rosette-forming glioneuronal tumor (C71._)

-S-

Schwannoma, NOS
Secretory meningioma
Smooth muscle tumor, NOS
Soft tissue perineurioma
Soft tissue tumor, benign
Solid teratoma
Solitary fibrous tumor
Solitary fibrous tumor/hemangiopericytoma Grade 1 (CNS) (C71._)
Solitary fibrous tumor/hemangiopericytoma Grade 2 (CNS) (C71._)
Subependymal astrocytoma, NOS
Subependymal giant cell astrocytoma
Subependymal glioma
Subependymoma
Superficial well differentiated liposarcoma
Syncytial meningioma

-T-

Teratoma, benign
Teratoma, differentiated
Teratoma, NOS
Transitional meningioma
Tumor cells, benign
Tumor cells, uncertain whether benign or malignant

-V-

Von Recklinghausen disease

APPENDIX C: *ICD-10-CM* CODE SCREENING LISTS FOR CASEFINDING

Revised for 2021 diagnoses.

The following list is intended to assist in casefinding activities that are performed in casefinding sources that use *ICD-10-CM* codes to codify the diagnoses.

Casefinding List for Reportable Tumors

***ICD-10-CM* Codes**	**Diagnoses (in preferred *ICD-O-3.2* terminology)**
C00._-C43._ C4A._ C45._-C96._	Malignant neoplasms (excluding categories C44 and C49.A), stated or presumed to be primary (of specified sites) and certain specified histologies
C44.00 C44.09	Unspecified/other malignant neoplasm of skin of lip
C44.10_ C44.19_	Unspecified/other malignant neoplasm of skin of eyelid
C44.13_	Sebaceous cell carcinoma of skin of eyelid, including canthus
C44.20_ C44.29_	Unspecified/other malignant neoplasm of skin of ear and external auricular canal
C44.30_ C44.39_	Unspecified/other malignant neoplasm of skin of other/unspecified parts of face
C44.40 C44.49	Unspecified/other malignant neoplasm of skin of scalp and neck
C44.50_ C44.59_	Unspecified/other malignant neoplasm of skin of trunk
C44.60_ C44.69_	Unspecified/other malignant neoplasm of skin of upper limb, including shoulder
C44.70_ C44.79_	Unspecified/other malignant neoplasm of skin of lower limb, including hip
C44.80 C44.89	Unspecified/other malignant neoplasm of overlapping sites of skin
C44.90 C44.99	Unspecified/other malignant neoplasm of unspecified sites of skin
C49.A_	Gastrointestinal stromal tumors (GIST) (Note: All GIST tumors are reportable starting in 2021 including GIST, NOS.)
D00._-D09._	In situ neoplasms (See reportability rules for reportable in situ neoplasms.)
D18.02	Hemangioma of intracranial structures and any site
D32._	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33._	Benign neoplasm of brain and other parts of central nervous system (CNS)
D35.2-D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42._ D43._	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3-D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3) ICD-10-CM coding instruction note: Excludes the following: • familial polycythemia (C75.0) • secondary polycythemia (D75.1)
D46._	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992, 9993)
D47.02	Systemic mastocytosis
D47.1	Chronic myeloproliferative disease (9963/3, 9975/3) ICD-10-CM coding instruction note: Excludes the following:

***ICD-10-CM* Codes**	**Diagnoses (in preferred *ICD-O-3.2* terminology)**
	• atypical chronic myeloid leukemia BCR/ABL-negative (C92.2_) • chronic myeloid leukemia BCR/ABL-positive (C92.1_) • myelofibrosis & secondary myelofibrosis (D75.81) • myelophthisic anemia & myelophthisis (D61.82).
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3) Includes the following: • essential thrombocytosis • idiopathic hemorrhagic thrombocythemia.
D47.4	Osteomyelofibrosis (9961/3) Includes the following: • chronic idiopathic myelofibrosis • myelofibrosis (idiopathic) (with myeloid metaplasia) • myelosclerosis (megakaryocytic) (with myeloid metaplasia) • secondary myelofibrosis in myeloproliferative disease.
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D47.Z _	Neoplasm of uncertain behavior of lymphoid, hematopoietic, and related tissue, unspecified (9960/3, 9970/1, 9971/3, 9931/3)
D49.6 D49.7	Neoplasms of unspecified nature of brain, endocrine glands and other CNS
D72.110	Idiopathic hypereosinophilic syndrome [HES]
D72.111	Lymphocytic variant hypereosinophilic Syndrome [LHES]
D72.118	Other hypereosinophilic syndrome
D72.119	Hypereosinophilic syndrome [HES], unspecified
R85.614	Cytologic evidence of malignancy on smear of anus
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.624	Cytologic evidence of malignancy on smear of vagina

Notes:
The State Cancer Registry will continue to collect pilocytic/juvenile astrocytoma, M-9421, as a behavior code /3 unless primary site is optic nerve, although the behavior was changed to code /1 in *ICD-O-3*. This is consistent with the SEER program guidelines.*01/01/2023 Behavior changed to /1 (ICD-O-3.2)

For cases diagnosed 1/01/2001 and later, the State Cancer Registry will not collect borderline cystadenomas M-8442, 8451, 8462, 8472, 8473, of the ovaries which changed from behavior code /3 in *ICD-O-2* to /1 in *ICD-O-3*. This is also consistent with the SEER program guidelines.

APPENDIX D-1: ALPHABETICAL LIST OF FACILITIES WITH IDENTIFICATION NUMBERS

Facility Name	Indiana ID Number	ACoS ID Number	NPI
Adams Memorial Hospital (Decatur)	001	6420240	1689696148
Baptist Health Floyd (New Albany)	029	6421045	1497798847
Bluffton Regional Medical Center (Bluffton)	009	6420140	1376594366
Cameron Memorial Community Hospital (Angola)	008	6420055	1386616
Cancer Care Partners (South Bend)	814	10001167	1265735674
Clark Memorial Health (Jeffersonville)	010	6420750	1134186315
Columbus Regional Health (Columbus)	004	6420200	1104998624
Community Hospital (Munster)	018	6421050	1003918210
Community Hospital Anderson (Anderson)	017	6420008	1972500452
Community Hospital East (Indianapolis)	014	6420605	1336119478
Community Hospital North (Indianapolis)	015	6420605	1619163854
Community Hospital of Bremen (Bremen)	016	6420165	1568417004
Community Hospital South (Indianapolis)	128	6420605	1235109778
Community Howard Regional Health (Kokomo)	041	6420775	1902878994
Community Surgery Center East (Indianapolis)	535	6420605	1891935201
Community Surgery Center North (Indianapolis)	534	6420605	1326286360
Community Surgery Center South (Indianapolis)	536	6420605	1659519684
Daviess Community Hospital (Washington)	020	6421460	1861465999
Deaconess Hospital (Evansville)	022	6420320	1053361642
Decatur County Memorial Hospital (Greensburg)	024	6420530	1952300477
Dukes Memorial Hospital (Peru)	025	6421120	1619920949
Dupont Hospital (Fort Wayne)	132	10000266	1538110556
Elkhart General Hospital (Elkhart)	027	6420270	1477551489
Eskenazi Health (Indianapolis) (formerly Wishard Health Services)	125	6420620	1568407310
Franciscan Health Crawfordsville (Crawfordsville)	019	6420220	1588774558
Franciscan Health Crown Point (Crown Point)	090	6420225	1336205798
Franciscan Health Dyer (Dyer)	076	6420560	1811077431
Franciscan Health Hammond (Hammond)	100	6420560	1306921911
Franciscan Health Indianapolis (Beech Grove)	093	10000014	1205931706
Franciscan Health Lafayette (Lafayette)	092	10000082	1356435341
Franciscan Health Rensselaer (Rensselaer)	048	6421180	1811962228
Franciscan Health Michigan City (Michigan City)	089	6421000	1710051941
Franciscan Health Munster (Munster)	574		1114173507
Gibson General Hospital (Princeton)	031	6421170	1558346007
Good Samaritan Hospital (Vincennes)	032	6421410	1225032881
Goshen Hospital (Goshen)	033	6420505	1740268846
Greene County General Hospital (Linton)	035	6420870	1184695389
Hancock Regional Hospital (Greenfield)	036	6420525	1467485003
Harrison County Hospital (Corydon)	037	6420215	1427165455
Hendricks Regional Health (Danville)	038	6420235	1669475950
Henry Community Health (New Castle)	039	6421080	1356428429
Integrated Cancer Care Greenwood	815		
Integrated Cancer Care Indianapolis	816		
IU Health Arnett Hospital (Lafayette)	154	10000922	1326296211
IU Health Ball Memorial Hospital (Muncie)	003	6421040	1225195340
IU Health Bedford Hospital (Bedford)	005	6424005	1548260284
IU Health Blackford Hospital (Hartford City)	006	6420570	1871574822
IU Health Bloomington (Bloomington)	007	6420130	1205860335
IU Health Frankfort Hospital (Frankfort)	012	6420460	1336190727
IU Health Jay Hospital (Portland)	049	6421160	1033115993
IU Health Morgan Hospital (Martinsville)	073	6420960	1730140591
IU Health North Hospital (Carmel)	138	10000624	1568492916

IU Health Paoli Hospital (Paoli)	075	6421108	1912984451
IU Health Saxony Hospital (Fishers)	156		1144266024
IU Health Tipton Hospital (Tipton)	108	6421370	1699876094
IU Health West Hospital (Avon)	135	10000569	1063443455
IU Health White Memorial Hospital (Monticello)	120	6421025	1710983945
IU Health Methodist Hospital (Indianapolis)	071	6420660	1144266024
IU Health University and Riley Hospitals (Indianapolis)	045	6420660	1144266024
Johnson Memorial Hospital (Franklin)	051	6420465	1750381596
King's Daughters' Health (Madison)	053	6420910	1518916048
Kosciusko Community Hospital (Warsaw)	055	6421440	1164475711
Logansport Memorial Hospital (Logansport)	065	6420880	1356320469
Logansport Regional Cancer Center (Logansport)	211		1568413144
Lutheran Hospital of Indiana (Fort Wayne)	059	6420420	1306897335
Madison Center and Hospital (South Bend)	152		1073565131
Madison County Cancer Care Center (Anderson)	808		1215988910
Major Hospital (Shelbyville)	122	6421270	1174555692
Margaret Mary Health (Batesville)	060	6420100	1558368449
Marion General Hospital (Marion)	061	6420920	1770679201
Memorial Hospital and Health Care Center (Jasper)	064	6420740	1003895947
Memorial Hospital of South Bend (South Bend)	067	6421290	1295772093
Methodist Hospitals (Gary)	069	6420495	1467504555
Monroe Hospital (Bloomington)	150	10000740	1831123942
Northwest Health - La Porte (La Porte)	057	6420850	1144277971
Northwest Health - Porter (Valparaiso)	079	6421390	1215151154
Northwest Health - Starke (Knox)	106	6420770	1003977075
Oncology Hematology Associates of SW Indiana (Evansville)	210		1437361516
Parkview DeKalb Hospital (Auburn)	021	6420085	1902897937
Parkview Huntington Hospital (Huntington)	043	6420590	1003821729
Parkview LaGrange Hospital (LaGrange)	056	6420830	1912008772
Parkview Noble Hospital (Kendallville)	063	6420760	1457366189
Parkview Regional Medical Center (Fort Wayne)	077	6420440	1366407603
Parkview Wabash Hospital (Wabash)	113	6421430	1245259878
Parkview Whitley Hospital (Columbia City)	121	6420197	1205844495
Perry County Memorial Hospital (Tell City)	078	6421325	1699779017
Pinnacle Hospital (Crown Point)	153		1801969670
Progressive Cancer Care (Marion)	811		1609984301
Pulaski Memorial Hospital (Winamac)	080	6421485	1306928213
Putnam County Hospital (Greencastle)	082	6420520	1912947490
Radiation Oncology Associates – GenesisCare (Fort Wayne)	812		1457337719
Reid Health (Richmond)	084	6421190	1063457380
Richard L. Roudebush V.A. Medical Center (Indianapolis)	086	6420735	1679687503
River View Surgery Center (Marion)	565		1285635417
Riverview Health (Noblesville)	085	6421098	1700883717
Rush Memorial Hospital (Rushville)	087	6421255	1497726020
Schneck Medical Center (Seymour)	047	6421260	1699738088
Scott Memorial Hospital (Scottsburg)	088	6421259	1154396604
St. Catherine Hospital (East Chicago)	091	6420260	1689776882
St. Elizabeth Dearborn Hospital (Lawrenceburg)	023	6420855	1326142498
St. Joseph Hospital (Fort Wayne)	097	6420450	1023060472
St. Joseph Regional Medical Center, Mishawaka Campus	099	6421300	1841245594
St. Joseph Regional Medical Center, Plymouth Campus	040	6421150	1174571129
St. Mary Medical Center (Hobart)	102	6420500	1558463745
St. Vincent Anderson (Anderson)	094	6420050	1457360356
St. Vincent Clay (Brazil)	011	6420157	1770533994
St. Vincent Dunn (Bedford)	026	6420110	1548205842
St. Vincent Evansville (Evansville)	103	10000047	1427082957
St. Vincent Indianapolis (Indianapolis)	104	6420710	1306898960
St. Vincent Jennings (North Vernon)	050	6421105	1285684829

St. Vincent Kokomo (Kokomo)	095	6420780	1780625442
St. Vincent Mercy (Elwood)	068	6420280	1477508596
St. Vincent Randolph (Winchester)	083	6421490	1609826783
St. Vincent Salem (Salem)	116	6421257	1124062419
St. Vincent Warrick (Boonville)	115	6420155	1205828803
St. Vincent Williamsport (Williamsport)	013	6421480	1518913565
Sullivan County Community Hospital (Sullivan)	062	6421310	1497759260
Surgical Hospital of Munster (Munster)	507		1720271844
Terre Haute Regional Hospital (Terre Haute)	107	6421360	1073550133
The Women's Hospital, Deaconess Health System (Newburgh)	131		1114023512
Union Hospital Clinton (Clinton)	112	6420190	1093713802
Union Hospital (Terre Haute)	110	6421366	1619975331
V.A. Northern Indiana Health Care System – Fort Wayne Campus	002	6420455	1568411791
Vantage Oncology at Evansville Cancer Center (Evansville)	204	6421198	1225274244
Witham Health Services (Lebanon)	126	6420860	1861613036
Woodlawn Hospital (Rochester)	127	6421220	1265413405

APPENDIX D-2: NUMERICAL LIST OF FACILITIES WITH IDENTIFICATION NUMBERS

Facility Name	Indiana ID Number	ACoS ID Number	NPI
Adams Memorial Hospital (Decatur)	001	6420240	1689696148
V.A. Northern Indiana Health Care System – Fort Wayne Campus	002	6420455	1568411791
IU Health Ball Memorial Hospital (Muncie)	003	6421040	1225195340
Columbus Regional Health (Columbus)	004	6420200	1104998624
IU Health Bedford Hospital (Bedford)	005	6424005	1548260284
IU Health Blackford Hospital (Hartford City)	006	6420570	1871574822
IU Health Bloomington (Bloomington)	007	6420130	1205860335
Cameron Memorial Community Hospital (Angola)	008	6420055	1386683316
Bluffton Regional Medical Center (Bluffton)	009	6420140	1376594366
Clark Memorial Health (Jeffersonville)	010	6420750	1134186315
St. Vincent Clay (Brazil)	011	6420157	1770533994
IU Health Frankfort Hospital (Frankfort)	012	6420460	1336190727
St. Vincent Williamsport (Williamsport)	013	6421480	1518913565
Community Hospital East (Indianapolis)	014	6420605	1336119478
Community Hospital North (Indianapolis)	015	6420605	1619163854
Community Hospital of Bremen (Bremen)	016	6420165	1568417004
Community Hospital Anderson (Anderson)	017	6420008	1972500452
Community Hospital (Munster)	018	6421050	1003918210
Franciscan Health Crawfordsville (Crawfordsville)	019	6420220	1588774558
Daviess Community Hospital (Washington)	020	6421460	1861465999
Parkview DeKalb Hospital (Auburn)	021	6420085	1902897937
Deaconess Hospital (Evansville)	022	6420320	1053361642
St. Elizabeth Dearborn Hospital (Lawrenceburg)	023	6420855	1326142498
Decatur County Memorial Hospital (Greensburg)	024	6420530	1952300477
Dukes Memorial Hospital (Peru)	025	6421120	1619920949
St. Vincent Dunn (Bedford)	026	6420110	1548205842
Elkhart General Hospital (Elkhart)	027	6420270	1477551489
Baptist Health Floyd (New Albany)	029	6421045	1497798847
Gibson General Hospital (Princeton)	031	6421170	1558346007
Good Samaritan Hospital (Vincennes)	032	6421410	1225032881
Goshen Hospital (Goshen)	033	6420505	1740268846
Greene County General Hospital (Linton)	035	6420870	1184695389
Hancock Regional Hospital (Greenfield)	036	6420525	1467485003
Harrison County Hospital (Corydon)	037	6420215	1427165455
Hendricks Regional Health (Danville)	038	6420235	1669475950
Henry Community Health (New Castle)	039	6421080	1356428429
St. Joseph Regional Medical Center, Plymouth Campus	040	6421150	1174571129
Community Howard Regional Health (Kokomo)	041	6420775	1902878994
Parkview Huntington Hospital (Huntington)	043	6420590	1003821729
IU Health University and Riley Hospitals (Indianapolis)	045	6420660	1144266024
Schneck Medical Center (Seymour)	047	6421260	1699738088
Franciscan Health Rensselaer (Rensselaer)	048	6421180	1811962228
IU Health Jay Hospital (Portland)	049	6421160	1033115993
St. Vincent Jennings (North Vernon)	050	6421105	1285684829
Johnson Memorial Hospital (Franklin)	051	6420465	1750381596
King's Daughters' Health (Madison)	053	6420910	1518916048
Kosciusko Community Hospital (Warsaw)	055	6421440	1164475711
Parkview LaGrange Hospital (LaGrange)	056	6420830	1912008772
Northwest Health - La Porte (La Porte)	057	6420850	1144277971
Lutheran Hospital of Indiana (Fort Wayne)	059	6420420	1306897335
Margaret Mary Health (Batesville)	060	6420100	1558368449
Marion General Hospital (Marion)	061	6420920	1770679201
Sullivan County Community Hospital (Sullivan)	062	6421310	1497759260

Parkview Noble Hospital (Kendallville)	063	6420760	1457366189
Memorial Hospital and Health Care Center (Jasper)	064	6420740	1003895947
Logansport Memorial Hospital (Logansport)	065	6420880	1356320469
Memorial Hospital of South Bend (South Bend)	067	6421290	1295772093
St. Vincent Mercy (Elwood)	068	6420280	1477508596
Methodist Hospital (Gary)	069	6420495	1467504555
IU Health Methodist Hospital (Indianapolis)	071	6420660	1144266024
IU Health Morgan Hospital (Martinsville)	073	6420960	1730140591
IU Health Paoli Hospital (Paoli)	075	6421108	1912984451
Franciscan Health Dyer (Dyer)	076	6420560	1811077431
Parkview Regional Medical Center (Fort Wayne)	077	6420440	1366407603
Perry County Memorial Hospital (Tell City)	078	6421325	1699779017
Northwest Health - Porter (Valparaiso)	079	6421390	1215151154
Pulaski Memorial Hospital (Winamac)	080	6421485	1306928213
Putnam County Hospital (Greencastle)	082	6420520	1912947490
St. Vincent Randolph (Winchester)	083	6421490	1609826783
Reid Health (Richmond)	084	6421190	1063457380
Riverview Health (Noblesville)	085	6421098	1700883717
Richard L. Roudebush V.A. Medical Center (Indianapolis)	086	6420735	1679687503
Rush Memorial Hospital (Rushville)	087	6421255	1497726020
Scott Memorial Hospital (Scottsburg)	088	6421259	1154396604
Franciscan Health Michigan City (Michigan City)	089	6421000	1710051941
Franciscan Health Crown Point (Crown Point)	090	6420225	1336205798
St. Catherine Hospital (East Chicago)	091	6420260	1689776882
Franciscan Health Lafayette (Lafayette)	092	10000082	1356435341
Franciscan Health Indianapolis (Beech Grove)	093	10000014	1205931706
St. Vincent Anderson (Anderson)	094	6420050	1457360356
St. Vincent Kokomo (Kokomo)	095	6420780	1780625442
St. Joseph Hospital (Fort Wayne)	097	6420450	1023060472
St. Joseph Regional Medical Center, Mishawaka Campus	099	6421300	1841245594
Franciscan Health Hammond (Hammond)	100	6420560	1306921911
St. Mary Medical Center (Hobart)	102	6420500	1558463745
St. Vincent Evansville (Evansville)	103	10000047	1427082957
St. Vincent Indianapolis (Indianapolis)	104	6420710	1306898960
Northwest Health - Starke (Knox)	106	6420770	1003977075
Terre Haute Regional Hospital (Terre Haute)	107	6421360	1073550133
IU Health Tipton Hospital (Tipton)	108	6421370	1699876094
Union Hospital (Terre Haute)	110	6421366	1619975331
Union Hospital Clinton (Clinton)	112	6420190	1093713802
Parkview Wabash Hospital (Wabash)	113	6421430	1245259878
St. Vincent Warrick (Boonville)	115	6420155	1205828803
St. Vincent Salem (Salem)	116	6421257	1124062419
IU Health White Memorial Hospital (Monticello)	120	6421025	1710983945
Parkview Whitley Hospital (Columbia City)	121	6420197	1205844495
Major Hospital (Shelbyville)	122	6421270	1174555692
Eskenazi Health (Indianapolis) (formerly Wishard Health Services)	125	6420620	1568407310
Witham Health Services (Lebanon)	126	6420860	1861613036
Woodlawn Hospital (Rochester)	127	6421220	1265413405
Community Hospital South (Indianapolis)	128	6420605	1235109778
The Women's Hospital, Deaconess Health System (Newburgh)	131		1114023512
Dupont Hospital (Fort Wayne)	132	10000266	1538110556
IU Health West Hospital (Avon)	135	10000569	1063443455
IU Health North Hospital (Carmel)	138	10000624	1568492916
Monroe Hospital (Bloomington)	150	10000740	1831123942
Madison Center and Hospital (South Bend)	152		1073565131
Pinnacle Hospital (Crown Point)	153		1801969670
IU Health Arnett Hospital (Lafayette)	154	10000922	1326296211
IU Health Saxony Hospital (Fishers)	156		1144266024

Vantage Oncology at Evansville Cancer Center (Evansville)	204	6421198	1225274244
Oncology Hematology Associates of SW Indiana (Evansville)	210		1437361516
Logansport Regional Cancer Center (Logansport)	211		1568413144
Surgical Hospital of Munster (Munster)	507		1720271844
Community Surgery Center North (Indianapolis)	534	6420605	1326286360
Community Surgery Center East (Indianapolis)	535	6420605	1891935201
Community Surgery Center South (Indianapolis)	536	6420605	1659519684
River View Surgery Center (Marion)	565		1285635417
Franciscan Health Munster (Munster)	574		1114173507
Madison County Cancer Care Center (Anderson)	808		1215988910
Progressive Cancer Care (Marion)	811		1609984301
Radiation Oncology Associates – GenesisCare (Fort Wayne)	812		1457337719
Cancer Care Partners (South Bend)	814	10001167	1265735674
Integrated Cancer Care Greenwood	815		
Integrated Cancer Care Indianapolis	816		

APPENDIX E: RULES FOR DETERMINING MULTIPLE PRIMARIES FOR LYMPHATIC AND HEMATOPOIETIC DISEASES

Definitions of single and subsequent primaries for hematologic malignancies based on *ICD-O-3* reportable malignancies, effective for cases diagnosed 01/01/2001 through 12/31/2009.

Cancer registrars are often faced with multiple pathology reports for patients with hematologic malignancies, and the diagnoses reported may require different morphology codes. This is due in part to the fact that more intensive diagnostic study may yield a more specific diagnosis, and in part to the natural histories of hematopoietic diseases, which may progress from one diagnosis into another.

The table on the following pages, provided to aid the registrar in determining single versus subsequent primaries, employs the following guidelines:

1. "Lymphoma" is a general term for hematopoietic solid malignancies of the lymphoid series. "Leukemia" is a general term for liquid malignancies of either the lymphoid or the myeloid series. While it is recognized that some malignancies occur predominantly (or even exclusively) in liquid or solid form, because so many malignancies can potentially arise as either leukemias or lymphomas (or both), all hematopoietic malignancies are assumed to have this potential.

2. Malignancies of the lymphoid series are considered to be different from those of the myeloid series. Therefore, a lymphoid malignancy arising after diagnosis of a myeloid malignancy (or myelodysplastic or myeloproliferative disorder) would be considered a subsequent primary; however, a myeloid malignancy diagnosed after a previous myeloid malignancy would not count as a subsequent primary. Histiocytic malignancies are considered different from both lymphoid and myeloid malignancies.

3. Hodgkin lymphoma is considered to be different from non-Hodgkin lymphoma (NHL). Among the NHLs, B-cell malignancies are considered different from T-cell/NK cell malignancies. Therefore, a B-cell malignancy arising later in the course of a patient previously diagnosed with a T-cell malignancy would be considered a subsequent primary. However, a T-cell malignancy diagnosed later in the same patient would not be considered a subsequent primary.

4. The sequence of diagnoses affects whether a diagnosis represents a subsequent primary. In some cases, the order of occurrence of the two diagnoses being compared is a factor in the decision as to whether the second diagnosis is a new primary.

How to Use the Table
Assign the *ICD-O-3* code to the first diagnosis and find the row containing that code. Assign the *ICD-O-3* code for the second diagnosis and find the column containing that code. In the cell at the intersection of the first diagnosis row and the second diagnosis column, an "**S**" symbol indicates that the two diagnoses are most likely the **same** disease process (prepare/update a single abstract), and a "**D**" indicates that they are most likely **different** disease processes (prepare more than one abstract).

Note 1: If one of the two diagnoses is an NOS (not otherwise specified) term and the other is more specific and determined to be the same disease process, code the more specific diagnosis regardless of the sequence. For example, if a diagnosis of non-Hodgkin lymphoma, NOS is followed by a diagnosis of follicular lymphoma, assign the morphology code for the follicular lymphoma.

Note 2: The table on the following pages and the "Complete Diagnostic Terms for Table (Based on *ICD-O-3*)" display only the *ICD-O-3* primary (boldfaced) term associated with the code. Refer to the *International Classification of Diseases, Third Edition* (*ICD-O-3*) for a complete list of related terms and synonyms.

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Second Diagnosis Across ➔ **🡻 First Diagnosis Down**		**1. 9590 Malignant lymphoma, NOS**	**2. 9591 NHL, NOS**	**3. 9596 Composite HD/NHL**	**4. 9650-9667 Hodgkin lymphoma**	**5. 9670-9671 ML, small B lymph**	**6. 9673 Mantle cell lymphoma**	**7. 9675-9684 ML, diff large B-cell**	**8. 9687 Burkitt lymphoma**	**9. 9689,9699 Marg zn, B-cl lymph**
1. Malignant lymphoma, NOS	**9590**	**S**	S	S	S	S	S	S	S	S
2. Malignant lymphoma, non-Hodgkin, NOS	**9591**	S	**S**	D	D	S	S	S	S	S
3. Composite HD/NHL	**9596**	S	S	**S**	S	S	S	S	S	S
4. Hodgkin lymphoma	**9650-9667**	S	D	D	**S**	D	D	D	D	D
5. Malignant lymphoma, small B lymphocytic	**9670-9671**	S	S	D	D	**S**	D	S	D	D
6. Mantle cell lymphoma	**9673**	S	S	D	D	D	**S**	D	D	D
7. Malignant lymphoma, diffuse, large B-cell	**9675-9684**	S	S	D	D	S	D	**S**	S	D
8. Burkitt lymphoma	**9687**	S	S	D	D	D	D	D	**S**	D
9. Marginal zone, B-cell lymphoma	**9689, 9699**	S	S	D	D	D	D	D	D	**S**
10. Follicular lymphoma	**9690-9698**	S	S	D	D	D	D	S	D	D
11. Mycosis fungoides, Sezary disease	**9700-9701**	S	S	D	D	D	D	D	D	D
12. T/NK-cell non-Hodgkin lymphoma	**9702-9719**	S	S	D	D	D	D	D	D	D
13. Precursor lymphoblastic lymphoma, NOS	**9727**	S	S	D	D	D	D	D	D	D
14. Precursor B-cell lymphoblastic lymphoma	**9728**	S	S	D	D	D	D	D	D	D
15. Precursor T-cell lymphoblastic lymphoma	**9729**	S	S	D	D	D	D	D	D	D
16. Plasma cell tumors	**9731-9734**	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	**9740-9742**	D	D	D	D	D	D	D	D	D
18. Histiocytosis/Langerhans cell histiocytosis	**9750-9756**	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	**9757-9758**	S	S	D	D	D	D	D	D	D
20. Immunoproliferative disease, NOS	**9760**	S	S	D	D	S	D	S	D	D
21. Waldenstrom macroglobulinemia	**9761**	S	S	D	D	S	D	S	D	D
22. Heavy chain disease, NOS	**9762**	S	S	D	D	D	D	D	D	D
23. Immunoproliferative small intestinal disease	**9764**	S	S	D	D	D	D	D	D	D
24. Leukemia/Acute leukemia, NOS	**9800-9801**	S	S	D	D	D	D	D	S	D
25. Acute biphenotypic leukemia	**9805**	S	S	D	D	S	S	S	S	S
26. Lymphocytic leukemia, NOS	**9820**	S	S	D	D	D	D	D	S	D
27. BCLL/SLL	**9823**	S	S	D	D	S	D	S	D	D
28. Burkitt cell leukemia	**9826**	S	S	D	D	D	D	D	S	D
29. Adult T-cell leukemia/lymphoma	**9827**	S	S	D	D	D	D	D	D	D
30. Prolymphocytic leukemia, NOS	**9832**	D	D	D	D	S	D	D	D	D
31. Prolymphocytic leukemia, B-cell	**9833**	D	D	D	D	S	D	D	D	D
32. Prolymphocytic leukemia, T-cell	**9834**	D	D	D	D	D	D	D	D	D
33. Precursor cell lymphoblastic leukemia, NOS	**9835**	S	S	D	D	D	D	D	D	D
34. Precursor B-cell lymphoblastic leukemia	**9836**	S	S	D	D	D	D	D	D	D
35. Precursor T-cell lymphoblastic leukemia	**9837**	S	S	D	D	D	D	D	D	D
36. Myeloid leukemias	**9840-9910**	D	D	D	D	D	D	D	D	D
37. Therapy related acute myelogenous leuk.	**9920**	D	D	D	D	D	D	D	D	D
38. Myeloid sarcoma	**9930**	D	D	D	D	D	D	D	D	D
39. Acute panmyelosis	**9931**	D	D	D	D	D	D	D	D	D
40. Hairy cell leukemia	**9940**	D	D	D	D	D	D	D	D	D
41. Chronic myelomonocytic leukemia	**9945**	D	D	D	D	D	D	D	D	D
42. Juvenile myelomonocytic leukemia	**9946**	D	D	D	D	D	D	D	D	D
43. NK-cell leukemia	**9948**	S	S	D	D	D	D	D	D	D
44. Polycythemia vera	**9950**	D	D	D	D	D	D	D	D	D
45. Chronic myeloproliferative disease	**9960**	D	D	D	D	D	D	D	D	D
46. Myelosclerosis	**9961**	D	D	D	D	D	D	D	D	D
47. Essential thrombocythemia	**9962**	D	D	D	D	D	D	D	D	D
48. Chronic neutrophilic leukemia	**9963**	D	D	D	D	D	D	D	D	D
49. Hypereosinophilic syndrome	**9964**	D	D	D	D	D	D	D	D	D
50. Refractory anemias	**9980-9986**	D	D	D	D	D	D	D	D	D
51. Therapy related MDS	**9987**	D	D	D	D	D	D	D	D	D
52. Myelodysplastic syndrome, NOS	**9989**	D	D	D	D	D	D	D	D	D

Key: S = one primary only; D = presumably a subsequent primary SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

Second Diagnosis Across ➔ **🡻 First Diagnosis Down**		**10. 9690-9698** Follicular lymphoma	**11. 9700-9701** MF, Sezary disease	**12. 9702-9719** T/NK-cell lymphoma	**13. 9727** Precursor lym'blas lymph NOS	**14. 9728** Precursor lym'blas lymph B-cl	**15. 9729** Precursor lym'blas lymph T-cl	**16. 9731-9734** Plasma cell tumors	**17. 9740-9742** Mast cell tumors	**18. 9750-9756** Histiocytosis; LCH
1. Malignant lymphoma, NOS	**9590**	S	S	S	S	S	S	S	S	S
2. Malignant lymphoma, non-Hodgkin, NOS	**9591**	S	S	S	S	S	S	D	D	D
3. Composite HD/NHL	**9596**	S	S	S	S	S	S	D	D	D
4. Hodgkin lymphoma	**9650-9667**	D	D	D	D	D	D	D	D	D
5. Malignant lymphoma, small B lymphocytic	**9670-9671**	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	**9673**	D	D	D	D	D	D	D	D	D
7. Malignant lymphoma, diffuse, large B-cell	**9675-9684**	S	D	D	D	D	D	D	D	D
8. Burkitt lymphoma	**9687**	D	D	D	D	D	D	D	D	D
9. Marginal zone, B-cell lymphoma	**9689, 9699**	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	**9690-9698**	**S**	D	D	D	D	D	D	D	D
11. Mycosis fungoides, Sezary disease	**9700-9701**	D	**S**	D	D	D	D	D	D	D
12. T/NK-cell non-Hodgkin lymphoma	**9702-9719**	D	D	**S**	D	D	D	D	D	D
13. Precursor lymphoblastic lymphoma, NOS	**9727**	D	D	D	**S**	S	S	D	D	D
14. Precursor B-cell lymphoblastic lymphoma	**9728**	D	D	D	S	**S**	D	D	D	D
15. Precursor T-cell lymphoblastic lymphoma	**9729**	D	D	D	S	D	**S**	D	D	D
16. Plasma cell tumors	**9731-9734**	D	D	D	D	D	D	**S**	D	D
17. Mast cell tumors	**9740-9742**	D	D	D	D	D	D	D	**S**	D
18. Histiocytosis/Langerhans cell histiocytosis	**9750-9756**	D	D	D	D	D	D	D	D	**S**
19. Dendritic cell sarcoma	**9757-9758**	D	D	D	D	D	D	D	D	D
20. Immunoproliferative disease, NOS	**9760**	D	D	D	D	D	D	S	D	D
21. Waldenstrom macroglobulinemia	**9761**	D	D	D	D	D	D	D	D	D
22. Heavy chain disease, NOS	**9762**	D	D	D	D	D	D	D	D	D
23. Immunoproliferative small intestinal disease	**9764**	D	D	D	D	D	D	S	D	D
24. Leukemia/Acute leukemia, NOS	**9800-9801**	D	D	S	S	S	S	D	D	D
25. Acute biphenotypic leukemia	**9805**	S	S	S	S	S	S	D	D	D
26. Lymphocytic leukemia, NOS	**9820**	S	S	S	S	S	S	D	D	D
27. BCLL/SLL	**9823**	D	D	D	D	D	D	D	D	D
28. Burkitt cell leukemia	**9826**	D	D	D	D	D	D	D	D	D
29. Adult T-cell leukemia/lymphoma	**9827**	D	D	D	D	D	D	D	D	D
30. Prolymphocytic leukemia, NOS	**9832**	D	D	D	D	D	D	D	D	D
31. Prolymphocytic leukemia, B-cell	**9833**	D	D	D	D	D	D	D	D	D
32. Prolymphocytic leukemia, T-cell	**9834**	D	D	D	D	D	D	D	D	D
33. Precursor cell lymphoblastic leukemia, NOS	**9835**	D	D	D	S	S	S	D	D	D
34. Precursor B-cell lymphoblastic leukemia	**9836**	D	D	D	S	S	D	D	D	D
35. Precursor T-cell lymphoblastic leukemia	**9837**	D	D	D	S	D	S	D	D	D
36. Myeloid leukemias	**9840-9910**	D	D	D	D	D	D	D	D	D
37. Therapy related acute myelogenous leuk.	**9920**	D	D	D	D	D	D	D	D	D
38. Myeloid sarcoma	**9930**	D	D	D	D	D	D	D	D	D
39. Acute panmyelosis	**9931**	D	D	D	D	D	D	D	D	D
40. Hairy cell leukemia	**9940**	D	D	D	D	D	D	D	D	D
41. Chronic myelomonocytic leukemia	**9945**	D	D	D	D	D	D	D	D	D
42. Juvenile myelomonocytic leukemia	**9946**	D	D	D	D	D	D	D	D	D
43. NK-cell leukemia	**9948**	D	D	S	D	D	D	D	D	D
44. Polycythemia vera	**9950**	D	D	D	D	D	D	D	D	D
45. Chronic myeloproliferative disease	**9960**	D	D	D	D	D	D	D	D	D
46. Myelosclerosis	**9961**	D	D	D	D	D	D	D	D	D
47. Essential thrombocythemia	**9962**	D	D	D	D	D	D	D	D	D
48. Chronic neutrophilic leukemia	**9963**	D	D	D	D	D	D	D	D	D
49. Hypereosinophilic syndrome	**9964**	D	D	D	D	D	D	D	D	D
50. Refractory anemias	**9980-9986**	D	D	D	D	D	D	D	D	D
51. Therapy related MDS	**9987**	D	D	D	D	D	D	D	D	D
52. Myelodysplastic syndrome, NOS	**9989**	D	D	D	D	D	D	D	D	D

Key: S = one primary only; D = presumably a subsequent primary SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

Second Diagnosis Across ➔ **🡻 First Diagnosis Down**		**19. 9757-9758** Dendritic cell sarc	**20. 9760** Immunoprolif dis	**21. 9761** Waldenstrom macro	**22. 9762** Heavy chain dis	**23. 9764** Imm sm intest dis	**24. 9800-9801** Leuk/Acu leuk NOS	**25. 9805** Acute biphenotypic leuk	**26. 9820** Lym'cyt leuk, NOS	**27. 9823** BCLL/SLL
1. Malignant lymphoma, NOS	**9590**	S	S	S	S	S	S	S	S	S
2. Malignant lymphoma, non-Hodgkin, NOS	**9591**	S	S	S	S	S	S	S	S	S
3. Composite HD/NHL	**9596**	D	S	S	S	S	S	D	S	S
4. Hodgkin lymphoma	**9650-9667**	D	D	D	D	D	D	D	D	D
5. Malignant lymphoma, small B lymphocytic	**9670-9671**	D	D	S	D	D	D	S	S	S
6. Mantle cell lymphoma	**9673**	D	D	D	D	D	D	S	D	D
7. Malignant lymphoma, diffuse, large B-cell	**9675-9684**	D	S	S	S	S	D	S	S	S
8. Burkitt lymphoma	**9687**	D	D	D	D	D	S	S	S	D
9. Marginal zone, B-cell lymphoma	**9689, 9699**	D	D	D	D	D	D	S	D	D
10. Follicular lymphoma	**9690-9698**	D	D	D	D	D	D	S	D	D
11. Mycosis fungoides, Sezary disease	**9700-9701**	D	D	D	D	D	D	S	S	D
12. T/NK-cell non-Hodgkin lymphoma	**9702-9719**	D	S	D	D	D	D	S	S	D
13. Precursor lymphoblastic lymphoma, NOS	**9727**	D	D	D	D	D	S	S	S	D
14. Precursor B-cell lymphoblastic lymphoma	**9728**	D	D	D	D	D	S	S	S	D
15. Precursor T-cell lymphoblastic lymphoma	**9729**	D	D	D	D	D	S	S	S	D
16. Plasma cell tumors	**9731-9734**	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	**9740-9742**	D	D	D	D	D	D	D	D	D
18. Histiocytosis/Langerhans cell histiocytosis	**9750-9756**	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	**9757-9758**	**S**	D	D	D	D	D	D	D	D
20. Immunoproliferative disease, NOS	**9760**	D	**S**	S	S	S	D	D	D	D
21. Waldenstrom macroglobulinemia	**9761**	D	S	**S**	D	D	D	D	S	S
22. Heavy chain disease, NOS	**9762**	D	S	D	**S**	S	D	D	S	S
23. Immunoproliferative small intestinal disease	**9764**	D	S	D	S	**S**	D	D	D	D
24. Leukemia/Acute leukemia, NOS	**9800-9801**	D	D	D	D	D	**S**	S	S	D
25. Acute biphenotypic leukemia	**9805**	D	D	D	D	D	S	**S**	S	S
26. Lymphocytic leukemia, NOS	**9820**	D	S	S	S	D	S	S	**S**	S
27. BCLL/SLL	**9823**	D	S	D	D	D	D	S	S	**S**
28. Burkitt cell leukemia	**9826**	D	D	D	D	D	S	S	S	D
29. Adult T-cell leukemia/lymphoma	**9827**	D	D	D	D	D	D	S	S	D
30. Prolymphocytic leukemia, NOS	**9832**	D	D	D	D	D	D	S	S	S
31. Prolymphocytic leukemia, B-cell	**9833**	D	D	D	D	D	D	S	S	S
32. Prolymphocytic leukemia, T-cell	**9834**	D	D	D	D	D	D	S	S	D
33. Precursor cell lymphoblastic leukemia, NOS	**9835**	D	D	D	D	D	S	S	S	D
34. Precursor B-cell lymphoblastic leukemia	**9836**	D	D	D	D	D	S	S	S	D
35. Precursor T-cell lymphoblastic leukemia	**9837**	D	D	D	D	D	S	S	S	D
36. Myeloid leukemias	**9840-9910**	D	D	D	D	D	S	S	D	D
37. Therapy related acute myelogenous leuk.	**9920**	D	D	D	D	D	S	S	D	D
38. Myeloid sarcoma	**9930**	D	D	D	D	D	S	S	D	D
39. Acute panmyelosis	**9931**	D	D	D	D	D	S	S	D	D
40. Hairy cell leukemia	**9940**	D	D	D	D	D	S	S	D	D
41. Chronic myelomonocytic leukemia	**9945**	D	D	D	D	D	S	S	D	D
42. Juvenile myelomonocytic leukemia	**9946**	D	D	D	D	D	S	S	D	D
43. NK-cell leukemia	**9948**	D	D	D	D	D	S	S	S	D
44. Polycythemia vera	**9950**	D	D	D	D	D	S	D	D	D
45. Chronic myeloproliferative disease	**9960**	D	D	D	D	D	S	S	D	D
46. Myelosclerosis	**9961**	D	D	D	D	D	S	S	D	D
47. Essential thrombocythemia	**9962**	D	D	D	D	D	S	D	D	D
48. Chronic neutrophilic leukemia	**9963**	D	D	D	D	D	S	D	D	D
49. Hypereosinophilic syndrome	**9964**	D	D	D	D	D	S	D	D	D
50. Refractory anemias	**9980-9986**	D	D	D	D	D	S	S	D	D
51. Therapy related MDS	**9987**	D	D	D	D	D	S	S	D	D
52. Myelodysplastic syndrome, NOS	**9989**	D	D	D	D	D	S	S	D	D

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Second Diagnosis Across ➔ **➔ First Diagnosis Down**		**28. 9826 Burkitt leukemia**	**29. 9827 Adult T-cell leuk/lym**	**30. 9832 Prolym leuk, NOS**	**31. 9833 Prolym leuk, B-cell**	**32. 9834 Prolym leuk, T-cell**	**33. 9835 Precursor leukemia, NOS**	**34. 9836 Precursor leukemia B-cell**	**35. 9837 Precursor leukemia T-cell**	**36. 9840-9910 Myeloid leukemias**
1. Malignant lymphoma, NOS	**9590**	S	S	S	S	S	S	S	S	S
2. Malignant lymphoma, non-Hodgkin, NOS	**9591**	S	S	D	D	D	S	S	S	D
3. Composite HD/NHL	**9596**	S	S	D	D	D	S	S	S	D
4. Hodgkin lymphoma	**9650-9667**	D	D	D	D	D	D	D	D	D
5. Malignant lymphoma, small B lymphocytic	**9670-9671**	D	D	S	S	D	D	D	D	D
6. Mantle cell lymphoma	**9673**	D	D	D	D	D	D	D	D	D
7. Malignant lymphoma, diffuse, large B-cell	**9675-9684**	D	D	S	S	D	D	D	D	D
8. Burkitt lymphoma	**9687**	S	D	D	D	D	D	D	D	D
9. Marginal zone, B-cell lymphoma	**9689, 9699**	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	**9690-9698**	D	D	D	D	D	D	D	D	D
11. Mycosis fungoides, Sezary disease	**9700-9701**	D	D	D	D	D	D	D	D	D
12. T/NK-cell non-Hodgkin lymphoma	**9702-9719**	D	D	D	D	D	D	D	D	D
13. Precursor lymphoblastic lymphoma, NOS	**9727**	D	D	D	D	D	S	S	S	D
14. Precursor B-cell lymphoblastic lymphoma	**9728**	D	D	D	D	D	S	S	D	D
15. Precursor T-cell lymphoblastic lymphoma	**9729**	D	D	D	D	D	S	D	S	D
16. Plasma cell tumors	**9731-9734**	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	**9740-9742**	D	D	D	D	D	D	D	D	D
18. Histiocytosis/Langerhans cell histiocytosis	**9750-9756**	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	**9757-9758**	D	D	D	D	D	D	D	D	D
20. Immunoproliferative disease, NOS	**9760**	D	D	D	D	D	D	D	D	D
21. Waldenstrom macroglobulinemia	**9761**	D	D	D	D	D	D	D	D	D
22. Heavy chain disease, NOS	**9762**	D	D	D	D	D	D	D	D	D
23. Immunoproliferative small intestinal disease	**9764**	D	D	D	D	D	D	D	D	D
24. Leukemia/Acute leukemia, NOS	**9800-9801**	S	S	D	D	D	S	S	S	S
25. Acute biphenotypic leukemia	**9805**	S	S	S	S	S	S	S	S	S
26. Lymphocytic leukemia, NOS	**9820**	S	S	S	S	S	S	S	S	D
27. BCLL/SLL	**9823**	D	D	S	S	D	D	D	D	D
28. Burkitt cell leukemia	**9826**	**S**	D	D	D	D	D	D	D	D
29. Adult T-cell leukemia/lymphoma	**9827**	D	**S**	D	D	D	D	D	D	D
30. Prolymphocytic leukemia, NOS	**9832**	D	D	**S**	S	S	D	D	D	D
31. Prolymphocytic leukemia, B-cell	**9833**	D	D	S	**S**	D	D	D	D	D
32. Prolymphocytic leukemia, T-cell	**9834**	D	S	S	D	**S**	D	D	D	D
33. Precursor cell lymphoblastic leukemia, NOS	**9835**	D	D	D	D	D	**S**	S	S	D
34. Precursor B-cell lymphoblastic leukemia	**9836**	D	D	D	D	D	S	**S**	D	D
35. Precursor T-cell lymphoblastic leukemia	**9837**	D	D	D	D	D	S	D	**S**	D
36. Myeloid leukemias	**9840-9910**	D	D	D	D	D	D	D	D	**S**
37. Therapy related acute myelogenous leuk.	**9920**	D	D	D	D	D	D	D	D	S
38. Myeloid sarcoma	**9930**	D	D	D	D	D	D	D	D	S
39. Acute panmyelosis	**9931**	D	D	D	D	D	D	D	D	S
40. Hairy cell leukemia	**9940**	D	D	D	D	D	D	D	D	D
41. Chronic myelomonocytic leukemia	**9945**	D	D	D	D	D	D	D	D	S
42. Juvenile myelomonocytic leukemia	**9946**	D	D	D	D	D	D	D	D	S
43. NK-cell leukemia	**9948**	D	D	D	D	D	D	D	D	D
44. Polycythemia vera	**9950**	D	D	D	D	D	D	D	D	D
45. Chronic myeloproliferative disease	**9960**	D	D	D	D	D	D	D	D	S
46. Myelosclerosis	**9961**	D	D	D	D	D	D	D	D	S
47. Essential thrombocythemia	**9962**	D	D	D	D	D	D	D	D	S
48. Chronic neutrophilic leukemia	**9963**	D	D	D	D	D	D	D	D	S
49. Hypereosinophilic syndrome	**9964**	D	D	D	D	D	D	D	D	S
50. Refractory anemias	**9980-9986**	D	D	D	D	D	D	D	D	S
51. Therapy related MDS	**9987**	D	D	D	D	D	D	D	D	S
52. Myelodysplastic syndrome, NOS	**9989**	D	D	D	D	D	D	D	D	S

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Second Diagnosis Across ➔ **➔ First Diagnosis Down**		**37. 9920** Therapy relat AML	**38. 9930** Myeloid sarcoma	**39. 9931** Acute panmyelosis	**40. 9940** Hairy cell leukemia	**41. 9945** Chronic myelomono leuk	**42. 9946** Juvenile myelomono leuk	**43. 9948** NK-cell leukemia	**44. 9950** Polycythemia vera	**45. 9960** Chr myeloprolif dis
1. Malignant lymphoma, NOS	**9590**	S	S	S	S	S	S	S	D	D
2. Malignant lymphoma, non-Hodgkin, NOS	**9591**	D	D	D	D	D	D	D	D	D
3. Composite HD/NHL	**9596**	D	D	D	D	D	D	D	D	D
4. Hodgkin lymphoma	**9650-9667**	D	D	D	D	D	D	D	D	D
5. Malignant lymphoma, small B lymphocytic	**9670-9671**	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	**9673**	D	D	D	D	D	D	D	D	D
7. Malignant lymphoma, diffuse, large B-cell	**9675-9684**	D	D	D	D	D	D	D	D	D
8. Burkitt lymphoma	**9687**	D	D	D	D	D	D	D	D	D
9. Marginal zone, B-cell lymphoma	**9689, 9699**	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	**9690-9698**	D	D	D	D	D	D	D	D	D
11. Mycosis fungoides, Sezary disease	**9700-9701**	D	D	D	D	D	D	D	D	D
12. T/NK-cell non-Hodgkin lymphoma	**9702-9719**	D	D	D	D	D	D	D	D	D
13. Precursor lymphoblastic lymphoma, NOS	**9727**	D	D	D	D	D	D	D	D	D
14. Precursor B-cell lymphoblastic lymphoma	**9728**	D	D	D	D	D	D	D	D	D
15. Precursor T-cell lymphoblastic lymphoma	**9729**	D	D	D	D	D	D	D	D	D
16. Plasma cell tumors	**9731-9734**	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	**9740-9742**	D	D	D	D	D	D	D	D	D
18. Histiocytosis/Langerhans cell histiocytosis	**9750-9756**	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	**9757-9758**	D	D	D	D	D	D	D	D	D
20. Immunoproliferative disease, NOS	**9760**	D	D	D	D	D	D	D	D	D
21. Waldenstrom macroglobulinemia	**9761**	D	D	D	D	D	D	D	D	D
22. Heavy chain disease, NOS	**9762**	D	D	D	D	D	D	D	D	D
23. Immunoproliferative small intestinal disease	**9764**	D	D	D	D	D	D	D	D	D
24. Leukemia/Acute leukemia, NOS	**9800-9801**	S	S	D	D	S	S	D	D	S
25. Acute biphenotypic leukemia	**9805**	S	S	S	S	S	S	S	D	S
26. Lymphocytic leukemia, NOS	**9820**	D	D	D	S	D	D	S	D	D
27. BCLL/SLL	**9823**	D	D	D	D	D	D	D	D	D
28. Burkitt cell leukemia	**9826**	D	D	D	D	D	D	D	D	D
29. Adult T-cell leukemia/lymphoma	**9827**	D	D	D	D	D	D	D	D	D
30. Prolymphocytic leukemia, NOS	**9832**	D	D	D	D	D	D	D	D	D
31. Prolymphocytic leukemia, B-cell	**9833**	D	D	D	D	D	D	D	D	D
32. Prolymphocytic leukemia, T-cell	**9834**	D	D	D	D	D	D	D	D	D
33. Precursor cell lymphoblastic leukemia, NOS	**9835**	D	D	D	D	D	D	D	D	D
34. Precursor B-cell lymphoblastic leukemia	**9836**	D	D	D	D	D	D	D	D	D
35. Precursor T-cell lymphoblastic leukemia	**9837**	D	D	D	D	D	D	D	D	D
36. Myeloid leukemias	**9840-9910**	S	S	S	D	S	S	D	D	S
37. Therapy related acute myelogenous leuk.	**9920**	**S**	S	S	D	S	S	D	D	D
38. Myeloid sarcoma	**9930**	S	**S**	S	D	S	S	D	D	S
39. Acute panmyelosis	**9931**	S	S	**S**	D	S	S	D	D	D
40. Hairy cell leukemia	**9940**	D	D	D	**S**	D	D	D	D	D
41. Chronic myelomonocytic leukemia	**9945**	S	S	S	D	**S**	S	D	D	S
42. Juvenile myelomonocytic leukemia	**9946**	S	S	S	D	S	**S**	D	D	D
43. NK-cell leukemia	**9948**	D	D	D	D	D	D	**S**	D	D
44. Polycythemia vera	**9950**	D	D	D	D	D	D	D	**S**	S
45. Chronic myeloproliferative disease	**9960**	S	S	S	D	S	D	D	D	**S**
46. Myelosclerosis	**9961**	S	S	S	D	S	S	D	D	S
47. Essential thrombocythemia	**9962**	S	S	S	D	S	D	D	D	S
48. Chronic neutrophilic leukemia	**9963**	S	S	S	D	S	D	D	D	S
49. Hypereosinophilic syndrome	**9964**	S	S	S	D	S	S	D	D	S
50. Refractory anemias	**9980-9986**	S	S	S	D	S	S	D	D	S
51. Therapy related MDS	**9987**	S	S	S	D	S	S	D	D	S
52. Myelodysplastic syndrome, NOS	**9989**	S	S	S	D	S	S	D	D	S

Key: S = one primary only; D = presumably a subsequent primary

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Second Diagnosis Across ➔ / ➧ First Diagnosis Down		46. 9961 Myelosclerosis	47. 9962 Essential thrombocythemia	48. 9963 Chr neutrophil leuk	49. 9964 Hypereosin syndr	50. 9980-9986 Refract anemias	51. 9987 Therapy rel MDS	52. 9989 Myelodys syn NOS
1. Malignant lymphoma, NOS	9590	D	D	D	D	D	D	D
2. Malignant lymphoma, non-Hodgkin, NOS	9591	D	D	D	D	D	D	D
3. Composite HD/NHL	9596	D	D	D	D	D	D	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D
5. Malignant lymphoma, small B lymphocytic	9670-9671	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D
7. Malignant lymphoma, diffuse, large B-cell	9675-9684	D	D	D	D	D	D	D
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D
9. Marginal zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D
11. Mycosis fungoides, Sezary disease	9700-9701	D	D	D	D	D	D	D
12. T/NK-cell non-Hodgkin lymphoma	9702-9719	D	D	D	D	D	D	D
13. Precursor lymphoblastic lymphoma, NOS	9727	D	D	D	D	D	D	D
14. Precursor B-cell lymphoblastic lymphoma	9728	D	D	D	D	D	D	D
15. Precursor T-cell lymphoblastic lymphoma	9729	D	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D
18. Histiocytosis/Langerhans cell histiocytosis	9750-9756	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D
20. Immunoproliferative disease, NOS	9760	D	D	D	D	D	D	D
21. Waldenstrom macroglobulinemia	9761	D	D	D	D	D	D	D
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D
23. Immunoproliferative small intestinal disease	9764	D	D	D	D	D	D	D
24. Leukemia/Acute leukemia, NOS	9800-9801	S	D	S	S	D	S	S
25. Acute biphenotypic leukemia	9805	S	D	D	D	S	S	S
26. Lymphocytic leukemia, NOS	9820	D	D	D	D	D	D	D
27. BCLL/SLL	9823	D	D	D	D	D	D	D
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D
29. Adult T-cell leukemia/lymphoma	9827	D	D	D	D	D	D	D
30. Prolymphocytic leukemia, NOS	9832	D	D	D	D	D	D	D
31. Prolymphocytic leukemia, B-cell	9833	D	D	D	D	D	D	D
32. Prolymphocytic leukemia, T-cell	9834	D	D	D	D	D	D	D
33. Precursor cell lymphoblastic leukemia, NOS	9835	D	D	D	D	D	D	D
34. Precursor B-cell lymphoblastic leukemia	9836	D	D	D	D	D	D	D
35. Precursor T-cell lymphoblastic leukemia	9837	D	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	S	S	S	S	D	S	S
37. Therapy related acute myelogenous leuk.	9920	S	D	D	D	D	S	S
38. Myeloid sarcoma	9930	S	S	S	D	D	S	S
39. Acute panmyelosis	9931	S	D	D	D	D	S	S
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D
41. Chronic myelomonocytic leukemia	9945	S	D	S	D	D	S	S
42. Juvenile myelomonocytic leukemia	9946	S	D	D	D	D	S	S
43. NK-cell leukemia	9948	D	D	D	D	D	D	D
44. Polycythemia vera	9950	S	D	D	D	D	D	D
45. Chronic myeloproliferative disease	9960	S	S	S	D	D	D	D
46. Myelosclerosis	9961	**S**	S	S	D	D	S	S
47. Essential thrombocythemia	9962	S	**S**	S	D	D	D	D
48. Chronic neutrophilic leukemia	9963	S	S	**S**	D	D	D	D
49. Hypereosinophilic syndrome	9964	S	D	D	**S**	D	D	D
50. Refractory anemias	9980-9986	S	D	D	D	**S**	S	S
51. Therapy related MDS	9987	S	D	D	D	S	**S**	S
52. Myelodysplastic syndrome, NOS	9989	S	D	D	D	S	S	**S**

Key: S = one primary only; D = presumably a subsequent primary SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

COMPLETE DIAGNOSTIC TERMS FOR TABLE (BASED ON *ICD-O-3*)

1	9590	Malignant lymphoma, NOS
2	9591	Malignant lymphoma, non-Hodgkin, NOS
3	9596	Composite Hodgkin and non-Hodgkin lymphoma
4	9650-9667	Hodgkin lymphoma (all subtypes)
5	9670-9671	Malignant lymphoma, small B lymphocytic
6	9673	Mantle cell lymphoma
7	9675-9684	Malignant lymphoma, diffuse large B-cell
8	9687	Burkitt lymphoma
9	9689, 9699	Marginal zone B-cell lymphoma
10	9690-9698	Follicular lymphoma
11	9700-9701	Mycosis fungoides and Sezary syndrome
12	9702-9719	T/NK-cell non-Hodgkin lymphoma
13	9727	Precursor cell lymphoblastic lymphoma, NOS
14	9728	Precursor B-cell lymphoblastic lymphoma
15	9729	Precursor T-cell lymphoblastic lymphoma
16	9731-9734	Plasma cell tumors
17	9740-9742	Mast cell tumors
18	9750-9756	Histiocytosis/Langerhans cell histiocytosis
19	9757-9758	Dendritic cell sarcoma
20	9760	Immunoproliferative disease, NOS
21	9761	Waldenstrom macroglobulinemia
22	9762	Heavy chain disease, NOS
23	9764	Immunoproliferative small intestinal disease
24	9800-9801	Leukemia, NOS/Acute leukemia, NOS
25	9805	Acute biphenotypic leukemia
26	9820	Lymphoid leukemia, NOS
27	9823	B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma
28	9826	Burkitt cell leukemia
29	9827	Adult T-cell leukemia/lymphoma (HTLV-1 positive)
30	9832	Prolymphocytic leukemia, NOS
31	9833	Prolymphocytic leukemia, B-cell type
32	9834	Prolymphocytic leukemia, T-cell type
33	9835	Precursor cell lymphoblastic leukemia, NOS
34	9836	Precursor B-cell lymphoblastic leukemia
35	9837	Precursor T-cell lymphoblastic leukemia
36	9840-9910	Myeloid leukemias
37	9920	Therapy related acute myelogenous leukemia
38	9930	Myeloid sarcoma
39	9931	Acute panmyelosis with myelofibrosis
40	9940	Hairy cell leukemia
41	9945	Chronic myelomonocytic leukemia, NOS
42	9946	Juvenile myelomonocytic leukemia
43	9948	Aggressive NK-cell leukemia
44	9950	Polycythemia vera
45	9960	Chronic myeloproliferative disease, NOS
46	9961	Myelosclerosis with myeloid metaplasia
47	9962	Essential thrombocythemia
48	9963	Chronic neutrophilic leukemia
49	9964	Hypereosinophilic syndrome
50	9980-9986	Refractory anemias
51	9987	Therapy related myelodysplastic syndrome, NOS
52	9989	Myelodysplastic syndrome, NOS

SEER Program, NCI, 02/28/2001. E-mail: seerweb@ims.nci.nih.gov

APPENDIX F: CODING TIPS

- Webinars are free on FLccSC with registration to the website and includes:
  - Indiana Department of Heath Monthly Webinar Series, 1 Category A CE (NCRA Approved)
  - NPCR free webinars of various topics
  - NAACCR webinars of various topics
  - And many more options to choose from!
- SEER*Educate has been updated with new modules (All primary sites qualify for CE approved-Category A) 2022; rationale has also been updated for 2022 with updated diagnosis year 2022 EOD, Summary Stage, Grade and SSDI practice:
  - Anus
  - Corpus Uterus
  - Esophagus
  - Hodgkin/NHL
  - Kidney
  - Liver
  - NET
  - Ovary
  - Pancreas
  - Thyroid
- SEER*Inquiry: Here you can find answers to questions related to Histology, Primary Site, Solid Tumor Rules. Ask a SEER Registrar allows you to ask difficult questions to a SEER Registrar and get a personal response via email.
- SEER Appendix C: Site Specific Coding Modules: Appendix C brings together the site-specific instructions needed to abstract a case, facilitating efficiency and accuracy. The site-specific coding modules include SEER Coding Guidelines, Extent of Disease, Site-Specific Neoadjuvant Therapy Effect coding documents, and Surgery of Primary Site codes. Select by diagnosis year.
- Cancer Programs News | ACS (facs.org), American College of Surgeons: Search for news and updates for CoC program including "The Brief", which supplies updates to CoC coding manuals.
  - CAnswer Forum: Here you can find answers to questions about AJCC Staging, Treatment Coding, Accreditation, RCRS, SSDI's, STORE Manual(s), and Standards (CoC). There is also a "Ask the Pathologist" forum. Free with registration. *Not for histology or primary site coding.
- **Minimum Text Guidelines**
  - **Follow text guidelines for each field as indicated below:**
    - Physical Exam Text
    - Xray/Scans Text
    - Labs Text
    - Operative/Diagnostic Procedure Text
    - Scope Text
    - Chemotherapy Text
    - Radiation Text
    - Hormone Text
    - Surgery Text
    - Other Treatment Text
    - Immunotherapy Text
    - Remarks Text
    - Pathology Text
    - Staging Text

For diagnosis years 01/01/2023 and forward, For cases diagnosed 2003-2022 use previous versions of ISCR Manual

APPENDIX G: SURGERY TREATMENT CODES

DEFINITIONS AND RULES
Additional site-specific definitions and rules may be found with the site-specific codes.

Surgical Procedure of Primary Site

a. 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, "Surgical Procedure of Primary Site" refers to the most invasive surgical procedure of the primary site.

b. For codes 00 through 79, the code **positions** are hierarchical. The codes' numeric sequence may deviate from the order in which the codes are listed. Last-listed codes take precedence over codes listed above, because:
   1) Within groups of codes, procedures are listed with increasing degrees of descriptive precision; and
   2) Succeeding groups of codes define progressively more extensive forms of resection.

   Example for RECTOSIGMOID (C19.9): A polypectomy with electrocautery is coded A220.

   A200 Local tumor excision, NOS
   A260 Polypectomy
   A270 Excisional biopsy
   A280 Polypectomy-endoscopic
   A290 Polypectomy-surgical excision
   Any combination of A200 or A260, A270, A280, or A290 WITH
   A220 Electrocautery

c. Use codes A800 and A900 only if more precise information about the surgery is unavailable.

d. Code A980 applies to specific tumors that cannot be clearly defined in terms of primary or non-primary site. Use code A980 for the following:

   - All hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies, WITH or WITHOUT surgical treatment;
   - All unknown and ill-defined disease sites, WITH or WITHOUT surgical treatment.

If any surgical treatment was performed on these cancers, assign code 1 in the item, "Surgical Procedure/Other Site."

e. Biopsies that remove all of the tumor and/or leave only microscopic margins are to be coded in "Surgical Procedure of Primary Site."

f. Surgery to remove regional tissue or organs is coded in "Surgical Procedure of Primary Site" only if the tissue/organs are removed in continuity with the primary site, except where noted in Appendix G.

g. 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. When multiple first course primary site surgical procedures are performed for a single tumor, the most extensive or definitive is the last performed, and the code should represent the cumulative effect of the separate procedures.

ORAL CAVITY (C00.0 – C06.9)

Lip C00.0-C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0-C02.9, Gum C03.0-C03.9, Floor of Mouth C04.0-C04.9, Palate C05.0-C05.9, Other Parts of Mouth C06.0-C06.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
- A110 Photodynamic therapy (PDT)
- A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- A130 Cryosurgery
- A140 Laser

No specimen sent to pathology from surgical events A100-A140.

A200 Local tumor excision, NOS
- A260 Polypectomy
- A270 Excisional biopsy
- Any combination of A200, A260, or A270 WITH
  - A210 Photodynamic therapy (PDT)
  - A220 Electrocautery
  - A230 Cryosurgery
  - A240 Laser ablation
- A250 Laser excision

A300 Wide excision, NOS

Code A300 includes:
Hemiglossectomy
Partial glossectomy

A400 Radical excision of tumor, NOS
- A410 Radical excision of tumor ONLY
- A420 Combination of A410 WITH resection in continuity with mandible (marginal, segmental, hemi-, or total resection)
- A430 Combination of A410 WITH resection in continuity with maxilla (partial, subtotal, or total resection)

Codes A400-A430 include:
Total glossectomy
Radical glossectomy

Specimen sent to pathology from surgical events A200-A430.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

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

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
- A110 Photodynamic therapy (PDT)
- A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- A130 Cryosurgery
- A140 Laser

No specimen sent to pathology from surgical events A100-A140.

A200 Local tumor excision, NOS
- A260 Polypectomy
- A270 Excisional biopsy
- Any combination of A200, A260, A270 WITH
  - A210 Photodynamic therapy (PDT)
  - A220 Electrocautery
  - A230 Cryosurgery
  - A240 Laser ablation
  - A250 Laser excision

A300 Less than total parotidectomy, NOS; less than total removal of major salivary gland, NOS
- A310 Facial nerve spared
- A320 Facial nerve sacrificed
- A330 Superficial lobe ONLY
  - A340 Facial nerve spared
  - A350 Facial nerve sacrificed
- A360 Deep lobe (Total)
  - A370 Facial nerve spared
  - A380 Facial nerve sacrificed

A400 Total parotidectomy, NOS; total removal of major salivary gland, NOS
- A410 Facial nerve spared
- A420 Facial nerve sacrificed

A500 Radical parotidectomy, NOS; radical removal of major salivary gland, NOS
- A510 WITHOUT removal of temporal bone
- A520 WITH removal of temporal bone
- A530 WITH removal of overlying skin (requires graft or flap coverage)

A800 Parotidectomy, NOS

Specimen sent to pathology from surgical events A200-A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

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

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
- A110 Photodynamic therapy (PDT)
- A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- A130 Cryosurgery
- A140 Laser
- A150 Stripping

No specimen sent to pathology from surgical events A100-A150.

A200 Local tumor excision, NOS
- A260 Polypectomy
- A270 Excisional biopsy
- Any combination of A200, A260, A270 WITH
  - A210 Photodynamic therapy (PDT)
  - A220 Electrocautery
  - A230 Cryosurgery
  - A240 Laser ablation
  - A250 Laser excision
  - A280 Stripping

A300 Pharyngectomy, NOS
- A310 Limited/partial pharyngectomy; tonsillectomy, bilateral tonsillectomy
- A320 Total pharyngectomy

A400 Pharyngectomy WITH laryngectomy OR removal of contiguous bone tissue, NOS (does NOT include total mandibular resection)
- A410 WITH laryngectomy (laryngopharyngectomy)
- A420 WITH bone
- A430 WITH both A410 and A420

A500 Radical pharyngectomy (includes total mandibular resection), NOS
- A510 WITHOUT laryngectomy
- A520 WITH laryngectomy

Specimen sent to pathology from surgical events A200-A520.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

ESOPHAGUS (C15.0 – C15.9)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
- A110 Photodynamic therapy (PDT)
- A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- A130 Cryosurgery
- A140 Laser

No specimen sent to pathology from surgical events A100-A140.

A200 Local tumor excision, NOS
- A260 Polypectomy
- A270 Excisional biopsy
- Any combination of A200 or A260, or A270 WITH
  - A210 Photodynamic therapy (PDT)
  - A220 Electrocautery
  - A230 Cryosurgery
  - A240 Laser ablation
  - A250 Laser excision

A300 Partial esophagectomy

A400 Total esophagectomy, NOS

A500 Esophagectomy, NOS WITH laryngectomy and/or gastrectomy, NOS
- A510 WITH laryngectomy
- A520 WITH gastrectomy, NOS
- A530 Partial gastrectomy
- A540 Total gastrectomy
- A550 Combination of A510 WITH any of A520-A540

A800 Esophagectomy, NOS

Specimen sent to pathology from surgical events A200-A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

STOMACH (C16.0 – C16.9)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
- A110 Photodynamic therapy (PDT)
- A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- A130 Cryosurgery
- A140 Laser

No specimen sent to pathology from surgical events A100-A140.

A200 Local tumor excision, NOS
- A260 Polypectomy
- A270 Excisional biopsy
- Any combination of A200, A260, or A270 WITH
  - A210 Photodynamic therapy (PDT)
  - A220 Electrocautery
  - A230 Cryosurgery
  - A240 Laser ablation
  - A250 Laser excision

A300 Gastrectomy, NOS (partial, subtotal, hemi-)
- A310 Antrectomy, lower (distal - less than 40% of stomach)***
- A320 Lower (distal) gastrectomy (partial, subtotal, hemi-)
- A330 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

Code A300 includes:

Partial gastrectomy, including a sleeve resection of the stomach
Billroth I: anastomosis to duodenum (duodenostomy)
Billroth II: anastomosis to jejunum (jejunostomy)

A400 Near-total or total gastrectomy, NOS
- A410 Near-total gastrectomy
- A420 Total gastrectomy

A total gastrectomy may follow a previous partial resection of the stomach.

A500 Gastrectomy, NOS WITH removal of a portion of esophagus
- A510 Partial or subtotal gastrectomy
- A520 Near-total or total gastrectomy

Codes A500-A520 are used for gastrectomy resection when only portions of esophagus are included in procedure.

A600 Gastrectomy with a resection in continuity with the resection of other organs, NOS***
- A610 Partial or subtotal gastrectomy, in continuity with the resection of other organs ***
- A620 Near-total or total gastrectomy, in continuity with the resection of other organs ***
- A630 Radical gastrectomy, in continuity with the resection of other organs ***

Codes A600-A630 are used for gastrectomy resections with organs other than esophagus. Portions of esophagus may or may not be included in the resection.

A800 Gastrectomy, NOS

Specimen sent to pathology from surgical events A200-A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

*** Incidental splenectomy NOT included

COLON (C18.0 – C18.9) (01/01/2023)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

(Diagnosed 01/01/2023-12/31/2023)

Note
Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site*.

Codes
A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

No specimen sent to pathology from surgical events A100-A140.

A200 Local tumor excision, NOS
A260 Polypectomy, NOS
A270 Excisional biopsy
A280 Polypectomy – endoscopic
A290 Polypectomy – surgical excision
Any combination of A200, A260, A270, A280, or A290 WITH
A220 Electrocautery

A300 Partial colectomy, segmental resection
A320 Plus resection of contiguous organ; example: small bowel, bladder

A400 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)
A410 Plus resection of contiguous organ; example: small bowel, bladder

A500 Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a portion of the rectum)
A510 Plus resection of contiguous organ; example: small bowel, bladder

A600 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)
A610 Plus resection of contiguous organ; example: small bowel, bladder

A700 Colectomy or coloproctectomy with resection of contiguous organ(s), NOS (where there is not enough information to code 32, 41, 51, or 61)
Code A700 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. Resection of other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, or pelvic exenteration.

A800 Colectomy, NOS

Specimen sent to pathology from surgical events A200-A800.

A900 Surgery, NOS
A990 Unknown if surgery performed; death certificate ONLY

COLON (C18.0 – C18.9) (01/01/2024)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

(Diagnosis 01/01/2024+)

Note: Code removal/surgical ablation of single or multiple liver metastases under the data item Surgical

B000 None; no surgery of primary site; autopsy ONLY

B100 Local tumor destruction, NOS
No specimen sent to pathology from surgical event B100

B200 Local tumor excision, NOS
B260 Polypectomy, NOS
B270 Excisional biopsy
B280 Polypectomy-endoscopic
Note: Code B280 includes a polypectomy during an initial colonoscopy for screening or symptoms without knowledge of whether the polyp is benign or malignant.
B281 Polypectomy-endoscopic mucosal resection or dissection
Note: Code B281 includes a more complicated polypectomy performed during a colonoscopy. Usually, the polyp is known to be a superficial malignancy.
B290 Polypectomy-open approach surgical excision, or laparoscopic

Any combination of B200, B260, B270, B280, B281, or B290 WITH
B220 Electrocautery
Note: Code B220 should be used when electrocautery is used to destroy the tumor but there is still tumor sent to pathology. Rarely used.

B291 Wide Local Excision with Tumor
Note: Code B291 includes procedures focused on just removing the primary tumor and not removing a portion of colon or rectum. In these local procedures the adjacent colon, rectum and lymph nodes are not removed, just the tumor with a bit of margin. Procedures are typically reserved for removal of early tumors that are superficial and not known to be associated with lymph node involvement. Alternate names for B291 include: Wide local excision, Wide excision, Local tumor resection, or Transanal resection.

B300 Partial colectomy, removal of one or more segments with colon resection but less than half of colon is removed
Note: Code B300 includes removal of one or more colon segments, but less than half of the colon. Segments include cecum, ascending colon, hepatic flexure, transverse colon, splenic flexure, sigmoid colon, and/or the descending colon.
• Transverse colectomy includes transverse colon
• Splenic flexure colectomy includes transverse colon and the splenic flexure
• Sigmoidectomy includes removal of sigmoid colon and descending colon

B320 Plus resection of contiguous organ; example: small bowel, bladder
B330 Appendectomy for an appendix primary only, includes incidental findings
Note: When an appendix primary is found incidentally during resection for a colon primary, code the extent of the surgical resection for the colon primary. Assign B330 for the appendix primary site.

B400 Hemicolectomy (total right or left colon and a portion of the transverse colon)
B401 Subtotal colectomy (total right or left colon and entire/all of transverse colon)
Note: Code B400 includes removal of the total right or left colon with a portion of the transverse colon.
• A total left hemicolectomy includes removal of the splenic flexure, descending colon, and the sigmoid colon

• A total right hemicolectomy includes removal of the cecum (with appendix, if present), ascending
colon and the hepatic flexure

B410 Plus resection of contiguous organ; example: small bowel, bladder
Note: Assign code B400 for extended left/right hemicolectomy.

B500 Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a portion of the rectum)
Note: Code B500 includes removal of all segments of colon, not including the entire rectum.

B510 Plus resection of contiguous organ; example: small bowel, bladder

B600 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)
Note: Code B600 includes removal of the entire colon, including the entire rectum

B610 Plus resection of contiguous organ; example: small bowel, bladder

B700 Colectomy or proctocolectomy with resection of contiguous organ(s), NOS
Note: Use code B700 when there is not enough information to assign code B320, B410, B510, or B610. Code B700 includes any colectomy (partial, hemicolectomy, or total) WITH a resection of any other organs in continuity with the primary site (en bloc resection). 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.

B800 Colectomy, NOS
Specimen sent to pathology from surgical events B200-B800

B900 Surgery, NOS

B990 Unknown if surgery performed; death certificate ONLY

RECTOSIGMOID (C19.9)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site.*

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
- A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

No specimen sent to pathology from surgical events A100-A140.

A200 Local tumor excision, NOS
- A260 Polypectomy
- A270 Excisional biopsy
- Combination of A200, A260 or A270 WITH
  - A220 Electrocautery

A300 Segmental resection; partial proctosigmoidectomy, NOS
- A310 Plus resection of contiguous organs; example: small bowel, bladder

Procedures coded A300 include, but are not limited to:
- Anterior resection
- Hartmann's operation
- Low anterior resection (LAR)
- Partial colectomy, NOS
- Rectosigmoidectomy, NOS
- Sigmoidectomy

A400 Pull through WITH sphincter preservation (colo-anal anastomosis)

A500 Total proctectomy

A510 Total colectomy

A550 Total colectomy WITH ileostomy, NOS
- A560 Ileorectal reconstruction
- A570 Total colectomy WITH other pouch; example: Koch pouch

A600 Total proctocolectomy, NOS
- A650 Total proctocolectomy WITH ileostomy, NOS
- A660 Total proctocolectomy WITH ileostomy and pouch
- **Removal of the colon from cecum to the rectosigmoid or a portion of the rectum.**

A700 Colectomy or proctocolectomy in continuity with other organs; pelvic exenteration

A800 Colectomy, NOS; proctectomy, NOS

Specimen sent to pathology from surgical events A200-A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

Terminology
Duhamel operation: A modification of a pull-through procedure with a longitudinal anastomosis between the proximal ganglionated segment of the colon and the rectum, leaving the rectum functional.

Hartmann's operation: A one-stage resection of primary rectal cancer with colostomy. The lower part of the sigmoid or the upper part of the rectum is resected distal to the neoplasm. The bowel is divided in the region of the descending colon. After the intervening segment of bowel has been removed, the proximal end of the descending colon is brought to the surface, as in a single-barreled colostomy. The proximal end of the distal segment is oversewn and left in place, leaving a blind rectal pouch.

Miles' operation: An abdominoperineal resection for cancer of the lower sigmoid and rectum, which includes permanent colostomy; removal of the pelvic colon, mesocolon, and adjacent lymph nodes; and wide perineal excision of the rectum and anus.

Pull-through operation: Permits removal of the desired portion of bowel (may include rectum, sigmoid, and, when indicated, descending colon and part of transverse colon) in one stage with retained sphincters, and end-to-end anastomosis. This operation is performed largely through the abdomen and does not require resection or removal of any part of the bony pelvis.

Swenson's operation: A pull-through resection with sphincter preservation.

Swenson's procedure: An abdomino-anal pull-through resection with partial internal sphincterectomy.

RECTUM (C20.9)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site.*

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
- A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

No specimen sent to pathology from surgical events A100-A120.

A200 Local tumor excision, NOS
- A260 Polypectomy
- A270 Excisional biopsy
- Any combination of A200, A260, or A270 WITH
  - A220 Electrocautery
- A280 Curette and fulguration

A300 Segmental resection; partial proctectomy, NOS

Procedures coded A300 include, but are not limited to:
- Anterior resection
- Hartmann's operation
- Low anterior resection (LAR)
- Transsacral rectosigmoidectomy

A400 Pull through WITH sphincter preservation (coloanal anastomosis)

A500 Total proctectomy

Procedures coded A500 include but are not limited to:
- Abdominoperineal resection

A600 Total proctocolectomy, NOS

A700 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration

A800 Proctectomy, NOS

Specimen sent to pathology from surgical events A200-A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

Terminology

Duhamel operation: A modification of a pull-through procedure with a longitudinal anastomosis between the proximal ganglionated segment of the colon and the rectum, leaving the rectum functional.

Hartmann's operation: A one-stage resection of primary rectal cancer with colostomy. The lower part of the sigmoid or the upper part of the rectum is resected distal to the neoplasm. The bowel is divided in the region of the descending colon. After the intervening segment of bowel has been removed, the proximal end of the descending colon is brought to the surface, as in a single-barreled colostomy. The proximal end of the distal segment is oversewn and left in place, leaving a blind rectal pouch.

Miles' operation: An abdominoperineal resection for cancer of the lower sigmoid and rectum, which includes permanent colostomy; removal of the pelvic colon, mesocolon, and adjacent lymph nodes; and wide perineal excision of the rectum and anus.

Pull-through operation: Permits removal of the desired portion of bowel (may include rectum, sigmoid, and, when indicated, descending colon and part of transverse colon) in one stage with retained sphincters, and end-to-end anastomosis. This operation is performed largely through the abdomen and does not require resection or removal of any part of the bony pelvis.

Swenson's operation: A pull-through resection with sphincter preservation.

Swenson's procedure: An abdomino-anal pull-through resection with partial internal sphincterectomy.

ANUS (C21.0 – C21.8)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
A150 Thermal ablation

No specimen sent to pathology from surgical events A100, A120, or A150.

A200 Local tumor excision, NOS
A260 Polypectomy
A270 Excisional biopsy
Any combination of A200, A260, or A270 WITH
A220 Electrocautery

A600 Abdominal perineal resection, NOS (APR)
A610 APR and sentinel node excision
A620 APR and unilateral inguinal lymph node dissection
A630 APR and bilateral inguinal lymph node dissection

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* or *Scope of Regional Lymph Node Surgery at This Facility.*

Specimen sent to pathology from surgical events A200-A630.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

LIVER AND INTRAHEPATIC BILE DUCTS (C22.0 – C22.1)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
- A110 Photodynamic therapy (PDT)
- A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- A130 Cryosurgery
- A140 Laser
- A150 Alcohol (Percutaneous Ethanol Injection - PEI)
- A160 Heat-Radio-frequency Ablation (RFA)
- A170 Other (ultrasound, acetic acid)

No specimen sent to pathology from surgical events A100-A170.

A200 Wedge resection or segmental resection, NOS
- A210 Wedge resection
- A220 Segmental resection, NOS
  - A230 One
  - A240 Two
  - A250 Three
  - A260 Segmental resection AND local tumor destruction

A300 Lobectomy, NOS
- A360 Right lobectomy
- A370 Left lobectomy
- A380 Lobectomy AND local tumor destruction

A500 Extended lobectomy, NOS (extended: resection of single lobe plus a segment of another lobe)
- A510 Right lobectomy
- A520 Left lobectomy
- A590 Extended lobectomy AND local tumor destruction

A600 Hepatectomy, NOS
- A610 Total hepatectomy and transplant

A650 Excision of a bile duct (for an intrahepatic bile duct primary only)
- A660 Excision of an intrahepatic bile duct PLUS partial hepatectomy

A750 Bile duct and hepatectomy WITH transplant

Specimen sent to pathology from surgical events A200-A750.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

PANCREAS (C25.0 – C25.9) (01/01/2023)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

(Diagnosed 01/01/2023-12/31/2023 only)

Codes

A000 None; no surgery of primary site; autopsy ONLY

A250 Local excision of tumor, NOS

A300 Partial pancreatectomy, NOS; example: distal

A350 Local or partial pancreatectomy and duodenectomy
- A360 WITHOUT distal/partial gastrectomy
- A370 WITH partial gastrectomy (Whipple)

A400 Total pancreatectomy

A600 Total pancreatectomy and subtotal gastrectomy or duodenectomy

A700 Extended pancreatoduodenectomy

A800 Pancreatectomy, NOS

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

PANCREAS (C25.0 – C25.9) (01/01/2024)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

(Diagnosis 01/01/2024+ only)

Codes

B000 None; no surgery of primary site; autopsy ONLY

B250 Local excision of tumor, NOS; example: Enucleation
Laser tumor destruction, thermal therapy, or ablation

B300 Partial pancreatectomy, NOS; example: Distal pancreatectomy or subtotal pancreatectomy

B350 Local or partial pancreatectomy and duodenectomy; example: Pancreaticoduodenectomy (Whipple Procedure)
B351 WITHOUT distal/partial gastrectomy
B352 WITH partial gastrectomy, Classic Whipple

B400 Total pancreatectomy

B600 Total pancreatectomy and subtotal gastrectomy and/or duodenectomy, extended pancreatoduodenectomy

B800 Pancreatectomy, NOS

B900 Surgery, NOS

B990 Unknown if surgery performed; death certificate ONLY

LARYNX (C32.0 – C32.9)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
- A110 Photodynamic therapy (PDT)
- A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- A130 Cryosurgery
- A140 Laser
- A150 Stripping

No specimen sent to pathology from surgical events A100-A150

A200 Local tumor excision, NOS
- A260 Polypectomy
- A270 Excisional biopsy
- Any combination of A200, A260, or A270 WITH
  - A210 Photodynamic therapy (PDT)
  - A220 Electrocautery
  - A230 Cryosurgery
  - A240 Laser ablation
  - A250 Laser excision
  - A280 Stripping

A300 Partial excision of the primary site, NOS; subtotal/partial laryngectomy, NOS; hemilaryngectomy, NOS
- A310 Vertical laryngectomy
- A320 Anterior commissure laryngectomy
- A330 Supraglottic laryngectomy

A400 Total or radical laryngectomy, NOS
- A410 Total laryngectomy ONLY
- A420 Radical laryngectomy ONLY

A500 Pharyngolaryngectomy

A800 Laryngectomy, NOS

Specimen sent to pathology from surgical events A200-A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

Terminology (Robbins et al. 1991):
A radical neck dissection includes the removal of all ipsilateral cervical lymph node groups, i.e., lymph nodes from levels I through V (submental, submandibular, cranial jugular, medial jugular, caudal jugular, dorsal cervical nodes along the accessory nerve, and supraclavicular), and removal of the spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle.

In a modified radical neck dissection the same lymph nodes are removed as in a radical neck dissection; however, one or more non-lymphatic structures are preserved.

A selective neck dissection is neck dissection with preservation of one or more lymph nodes group routinely removed in radical neck dissection.

LUNG (C34.0 – C34.9) (01/01/2023)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

(Diagnosed 01/01/2023-12/31/2023 only)

Codes

A000 None; no surgery of primary site; autopsy ONLY

A190 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded A190 (principally for cases diagnosed prior to January 1, 2003).

A150 Local tumor destruction, NOS
- A120 Laser ablation or cryosurgery
- A130 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

No specimen sent to pathology from surgical events A120, A130, and A150.

A200 Excision or resection of less than one lobe, NOS
- A230 Excision, NOS
- A240 Laser excision
- A250 Bronchial sleeve resection ONLY
- A210 Wedge resection
- A220 Segmental resection, including lingulectomy

A300 Resection of lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)
- A330 Lobectomy WITH mediastinal lymph node dissection

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* or *Scope of Regional Lymph Node Surgery at This Facility.*

A450 Lobe or bilobectomy extended, NOS
- A460 WITH chest wall
- A470 WITH pericardium
- A480 WITH diaphragm

A550 Pneumonectomy, NOS
- A560 WITH mediastinal lymph node dissection (radical pneumonectomy)

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* or *Scope of Regional Lymph Node Surgery at This Facility.*

A650 Extended pneumonectomy
- A660 Extended pneumonectomy plus pleura or diaphragm

A700 Extended radical pneumonectomy

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* or *Scope of Regional Lymph Node Surgery at This Facility.*

A800 Resection of lung, NOS

Specimen sent to pathology from surgical events A200-A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

LUNG (C34.0 – C34.9) (01/01/2024)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

(Diagnosis 01/01/2024+)

Codes

B000 None; no surgery of primary site; autopsy ONLY

B150 Local tumor destruction, NOS

B120 Laser ablation or cryosurgery

B130 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

No specimen sent to pathology from surgical events B120, B130, and B150.

B190 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded B190

B200 Excision or resection of less than one lobe, NOS

B210 Wedge resection

B220 Segmental resection, including lingulectomy

B230 Excision, NOS

B240 Laser excision

B250 Bronchial sleeve resection ONLY

B300 Resection of lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)

B320 Bronchial sleeve lobectomy/bilobectomy

B330 Lobectomy WITH mediastinal lymph node dissection

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* or *Scope of Regional Lymph Node Surgery at This Facility.*

B450 Lobe or bilobectomy extended, NOS

B460 WITH chest wall

B470 WITH pericardium

B480 WITH diaphragm

B550 Pneumonectomy, NOS

B560 WITH mediastinal lymph node dissection (radical pneumonectomy)

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* or *Scope of Regional Lymph Node Surgery at This Facility.*

B650 Extended pneumonectomy

B660 Extended pneumonectomy plus pleura or diaphragm

B800 Resection of lung, NOS

Specimen sent to pathology from surgical events A200-A800.

B900 Surgery, NOS

B990 Unknown if surgery performed; death certificate ONLY

HEMATOPOIETIC/RETICULOENDOTHELIAL/IMMUNOPROLIFERATIVE/MYELOPROLIFERATIVE DISEASE (C42.0, C42.1, C42.3, C42.4)

C42.0, C42.1, C42.3, C42.4 (with any histology) or

9727, 9732, 9741-9742, 9749, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9968, and 9975-9993 (with any site)

Code

A980 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* or *Surgical Procedure/Other Site at This Facility.*

BONES, JOINTS, AND ARTICULAR CARTILAGE (40.0 – 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, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

Codes

A000 None; no surgery of primary site; autopsy ONLY

A190 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded A190 (principally for cases diagnosed prior to January 1, 2003).

A150 Local tumor destruction

No specimen sent to pathology from surgical event A150.

A250 Local excision

A260 Partial resection

A300 Radical excision or resection of lesion WITH limb salvage

A400 Amputation of limb
- A410 Partial amputation of limb
- A420 Total amputation of limb

A500 Major amputation, NOS
- A510 Forequarter, including scapula
- A520 Hindquarter, including ilium/hip bone
- A530 Hemipelvectomy
- A540 Internal hemipelvectomy

Specimen sent to pathology from surgical events A250-A540.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

SPLEEN (C42.2)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

Codes

A000 None; no surgery of primary site; autopsy ONLY

A190 Local tumor destruction or excision, NOS.
Unknown whether a specimen was sent to pathology for surgical events coded A190 (principally for cases diagnosed prior to January 1, 2003).

A210 Partial splenectomy

A220 Total splenectomy

A800 Splenectomy, NOS

Specimen sent to pathology from surgical events A210-A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

SKIN (C44.0 – C44.9)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

All 2023 site specific surgery codes begin with a letter A except for skin which start with a letter B to indicate a significate change in coding.

The **priority order** for sources used to assign surgery codes is: Operative report, statement from a physician, description of the surgical procedure on a pathology report, results of the pathology report. Code based on the description of the procedure.

Do not code based on margin status documented in the pathology report.

Codes

B000 None; no surgery of primary site; autopsy ONLY

B100 Local tumor destruction, NOS
- B110 Photodynamic therapy (PDT)
- B120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- B130 Cryosurgery
- B140 Laser ablation

No specimen sent to pathology from surgical events B100-B140.

B200 Local tumor excision, NOS
- B220 Shave Biopsy, NOS
- B230 Punch Biopsy, NOS
- B240 Elliptical Biopsy (aka fusiform)

B300 Mohs surgery, NOS
- B310 Mohs surgery performed on the same day (all Mohs procedures performed during the same day)
- B320 Mohs surgery performed on different days (slow Mohs) (each Mohs procedure performed on different day)

B500 Biopsy (NOS) of primary tumor followed by wide excision of the lesion; Wide Excision NOS, Re-excision

Note: An incisional biopsy would be a needle or core biopsy of the primary tumor. An incisional biopsy would be coded as a Surgical Diagnostic and Staging Procedure

B600 Major amputation

Specimen sent to pathology from surgical events B200-B600.

B900 Surgery, NOS

B990 Unknown if surgery performed; death certificate ONLY

BREAST (C50.0 – C50.9) (01/01/2023)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

(Diagnosed 01/01/2023-12/31/2023)

Codes

A000 None; no surgery of primary site; autopsy ONLY

A190 Local tumor destruction, NOS

No specimen was sent to pathology for surgical events coded A190 (principally for cases diagnosed prior to January 1, 2003).

A200 Partial mastectomy, NOS; less than total mastectomy, NOS
- A210 Partial mastectomy WITH nipple resection
- A220 Lumpectomy or excisional biopsy
- A230 Re-excision of the biopsy site for gross or microscopic residual disease
- A240 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

Procedures coded as A200-A240 remove gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.

A300 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 A300 may be considered to have undergone breast reconstruction.

A400 Total (simple) mastectomy
- A410 WITHOUT removal of uninvolved contralateral breast
  - A430 With reconstruction, NOS
    - A440 Tissue
    - A450 Implant
    - A460 Combined (Tissue and Implant)
- A420 WITH removal of uninvolved contralateral breast
  - A470 With reconstruction, NOS
    - A480 Tissue
    - A490 Implant
    - A750 Combined (Tissue and Implant)

Note: "Tissue" reconstruction involves human tissue such as muscle (latissimus dorsi or rectus abdominis) or skin.

- Do not code the use of acellular dermal matrix/AlloDerm in a reconstruction as a combined tissue and implant reconstruction.
- Do not code the use of tissue expander as tissue reconstruction. The placement of tissue expander is a preparation for reconstruction.
- Assign code A430 for a simple mastectomy with tissue expander and acellular dermal matrix/AlloDerm. Update the code when the actual reconstruction is documented.

A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done, but sentinel lymph nodes may be removed.

If contralateral breast reveals a second primary, each breast is abstracted separately. The surgical procedure is coded A410 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 A430-A460, A470-A490, or A750; whether it is done at the time of mastectomy or later.

A760 Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma

A500 Modified radical mastectomy
- A510 WITHOUT removal of uninvolved contralateral breast
  - A530 With reconstruction, NOS
    - A540 Tissue
    - A550 Implant
    - A560 Combined (Tissue and Implant)
- A520 WITH removal of uninvolved contralateral breast
  - A570 With reconstruction, NOS
    - A580 Tissue
    - A590 Implant
    - A630 Combined (Tissue and Implant)

See notes under total (simple) mastectomy that define “tissue” reconstruction and “tissue expander” procedures.

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.

Assign code A510 or A520 if a patient has an excisional biopsy and axillary dissection followed by a simple mastectomy during the first course of therapy. Code the cumulative result of the surgeries, which is a modified radical mastectomy in this case.]

If **contralateral breast** reveals a **second primary**, it is abstracted separately. The surgical procedure is coded A510 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* or *Surgical Procedure/Other Site at This Facility.*

A600 Radical mastectomy, NOS
- A610 WITHOUT removal of uninvolved contralateral breast
  - A640 With reconstruction, NOS
    - A650 Tissue
    - A660 Implant
    - A670 Combined (Tissue and Implant)
- A620 WITH removal of uninvolved contralateral breast
  - A680 With reconstruction, NOS
    - A690 Tissue
    - A730 Implant
    - A740 Combined (Tissue and Implant)

A700 Extended radical mastectomy
- A710 WITHOUT removal of uninvolved contralateral breast
- A720 WITH removal of uninvolved contralateral breast

A800 Mastectomy, NOS

Specimen sent to pathology for surgical events coded A200-A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

Terminology

Goldilocks mastectomy: A mastectomy that reconstructs a breast mound from cutaneous mastectomy flap tissue alone without the need for additional tissue transfer or prosthetic implant techniques. The nipple may or may not be preserved. The choice between code A300 and codes in the A400-A490 range depends on the extent of the breast removal and requires careful review of the operative report.

Halsted radical mastectomy: An en bloc resection of the entire breast and skin; pectoralis major and minor muscles; and contents of the axilla.

Patey's and Dyson's operations: Modified radical mastectomies with removal of the breast, pectoralis minor muscle, and axillary contents. The pectoralis major muscle remains intact.

Urban's extended radical mastectomy: Radical mastectomy and excision of internal mammary nodes.

BREAST (C50.0 – C50.9) (01/01/2024)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

(Diagnosis 01/01/2024+)

Codes

B000 None; no surgery of primary site; autopsy ONLY

B200 Partial mastectomy; less than total mastectomy; lumpectomy, segmental mastectomy, quadrantectomy, tylectomy, with or without nipple resection
Note: Use code B200 when there is a previous positive biopsy (either core or FNA).

B210 Excisional breast biopsy - Diagnostic excision, no pre-operative biopsy proven diagnosis of cancer
Note: Use code B210 when a surgeon removes the (positive) mass and there was no biopsy(either core or FNA) done prior to the mass being removed.
An excisional biopsy can occur when the nodule was previously not expected to be cancer.

B215 Excisional breast biopsy, for atypia
Note: Use code B215 when patient has biopsy that shows atypical ductal hyperplasia (ADH), an excision is then performed, and pathology shows in situ or invasive cancer.
The excisional breast biopsy for ADH diagnosed the cancer, not the core biopsy.
An excisional breast biopsy removes the entire tumor and/or leaves only microscopic margins.
This surgical code was added for situations when atypia tissue is excised and found to be reportable. Approx. 10-15% of excised atypia are cancer and reportable.

B240 Re-excision of margins from primary tumor site for gross or microscopic residual disease when less than total mastectomy performed

B290 Central lumpectomy, only performed for a prior diagnosis of cancer, which includes removal of the nipple areolar complex
Note: Use code B290 when the nipple areolar complex needs to be removed for patients with Paget disease or cancer directly involving the nipple areolar complex.
A central lumpectomy removes the nipple areolar complex, whereas a lumpectomy does not.
Central lumpectomy and central portion lumpectomy, central portion excision, central partial mastectomy are interchangeable terms.

B300 Skin-sparing mastectomy
Note: A skin-sparing mastectomy removes all breast tissue and the nipple areolar complex and preserves native breast skin. It is performed with and without sentinel node biopsy or axillary lymph node dissection (ALND).

B400 Nipple-sparing mastectomy
B410 WITHOUT removal of uninvolved contralateral breast
B420 WITH removal of uninvolved contralateral breast
Note: A nipple-sparing mastectomy removes all breast tissue but preserves the nipple areolar complex and breast skin. It is performed with and without sentinel node biopsy or ALND.

B500 Areolar-sparing mastectomy
B510 WITHOUT removal of uninvolved contralateral breast
B520 WITH removal of uninvolved contralateral breast
Note: An areolar-sparing mastectomy removes all breast tissue and the nipple but preserves the areola and breast skin. It is performed with and without sentinel node biopsy or ALND.

Assign code B510 or B520 if a patient has an excisional biopsy followed by an areolar-sparing mastectomy during the first course of therapy. Code the cumulative result of the surgeries, which is an

areolar-sparing mastectomy in this case.

B600 Total (simple) mastectomy
- B610 WITHOUT removal of uninvolved contralateral breast
- B620 WITH removal of uninvolved contralateral breast

Note: A total (simple) mastectomy removes all breast tissue, the nipple, areolar complex, and breast skin. It is performed with and without sentinel node biopsy or ALND.
Use code B600, B610, B620 if patient had a modified radical mastectomy.

B700 Radical mastectomy, NOS
- B710 WITHOUT removal of uninvolved contralateral breast
- B720 WITH removal of uninvolved contralateral breast
- B760 Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma

A radical mastectomy removes all breast tissue, the nipple areolar complex, breast skin, and pectoralis muscle. It is performed with level I-III ALND.

B800 Mastectomy, NOS (including extended radical mastectomy)

B900 Surgery, NOS

B990 Unknown if surgery performed; death certificate ONLY

CERVIX UTERI (C53.0 – C53.9)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

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

Codes

A000 None; no surgery of primary site, autopsy ONLY

A100 Local tumor destruction, NOS
- A110 Photodynamic therapy (PDT)
- A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- A130 Cryosurgery
- A140 Laser
- A150 Loop Electrocautery Excision Procedure (LEEP)
- A160 Laser ablation
- A170 Thermal ablation

No specimen sent to pathology from surgical events A100-A170.

A200 Local tumor excision, NOS
- A260 Excisional biopsy, NOS
- A270 Cone biopsy
- A240 Cone biopsy WITH gross excision of lesion
- A290 Trachelectomy; removal of cervical stump; cervicectomy
- Any combination of A200, A240, A260, A270, or A290 WITH
  - A210 Electrocautery
  - A220 Cryosurgery
  - A230 Laser ablation or excision
- A250 Dilatation and curettage; endocervical curettage (for in situ only)
- A280 Loop Electrocautery Excision Procedure (LEEP)

A300 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.

A400 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.

A500 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 51 Modified radical hysterectomy
- 52 Extended hysterectomy
- 53 Radical hysterectomy; Wertheim's procedure
- 54 Extended radical hysterectomy

A600 Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries
- 61 WITHOUT removal of tubes and ovaries
- 62 WITH removal of tubes and ovaries

A700 Pelvic exenteration
- A710 Anterior exenteration
  Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.
- A720 Posterior exenteration
  Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

A730 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.

A740 Extended exenteration
Includes pelvic blood vessels or bony pelvis

Specimen sent to pathology from surgical events 20-74.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

Terminology
Wertheim's operation: A radical abdominal hysterectomy for cancer of the cervix and uterus. The uterus and as much of the parametrial tissue as possible are removed, as well as a wide margin of the vagina.

CORPUS UTERI (C54.0 – C55.9)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

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

Codes

A000 None; no surgery of primary site; autopsy ONLY

A190 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded A190 (principally for cases diagnosed prior to January 1, 2003).

A100 Local tumor destruction, NOS
- A110 Photodynamic therapy (PDT)
- A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- A130 Cryosurgery
- A140 Laser
- A150 Loop Electrocautery Excision Procedure (LEEP)
- A160 Thermal ablation

No specimen sent to pathology from surgical events A100-A160.

A200 Local tumor excision, NOS; simple excision, NOS
- A240 Excisional biopsy
- A250 Polypectomy
- A260 Myomectomy

Any combination of A200 or A240-A260 WITH
- A210 Electrocautery
- A220 Cryosurgery
- A230 Laser ablation or excision

A300 Subtotal hysterectomy/supracervical hysterectomy/fundectomy WITH or WITHOUT removal of tube(s) and ovary(ies)
- A310 WITHOUT tube(s) and ovary(ies)
- A320 WITH tube(s) and ovary(ies)

A400 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.

A500 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.

A600 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- A610 Modified radical hysterectomy
- A620 Extended hysterectomy
- A630 Radical hysterectomy; Wertheim's procedure
- A640 Extended radical hysterectomy

A650 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies)
- A660 WITHOUT removal of tube(s) and ovary(ies)
- A670 WITH removal of tube(s) and ovary(ies)

A750 Pelvic exenteration

A760 Anterior exenteration
Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

A770 Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

A780 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.

A790 Extended exenteration
Includes pelvic blood vessels or bony pelvis

Specimen sent to pathology from surgical events A200-A790.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

Terminology
Wertheim's operation: A radical abdominal hysterectomy for cancer of the cervix and uterus. The uterus and as much of the parametrial tissue as possible are removed, as well as a wide margin of the vagina.

OVARY (C56.9)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

Codes

A000 None; no surgery of primary site; autopsy ONLY

A170 Local tumor destruction, NOS
No specimen sent to pathology from surgical event A170.

A250 Total removal of tumor or (single) ovary, NOS
A260 Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
A270 WITHOUT hysterectomy
A280 WITH hysterectomy

A350 Unilateral (salpingo-) oophorectomy; unknown if hysterectomy done
A360 WITHOUT hysterectomy
A370 WITH hysterectomy

A500 Bilateral (salpingo-) oophorectomy; unknown if hysterectomy done
A510 WITHOUT hysterectomy
A520 WITH hysterectomy

A550 Unilateral or bilateral (salpingo-) oophorectomy WITH OMENTECTOMY, NOS (partial or total); unknown if hysterectomy done
A560 WITHOUT hysterectomy
A570 WITH hysterectomy

A600 Debulking; cytoreductive surgery, NOS
A610 WITH colon (including appendix) and/or small intestine resection (not incidental)
A620 WITH partial resection of urinary tract (not incidental)
A630 Combination of A610 and A620
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.

A700 Pelvic exenteration, NOS
A710 Anterior exenteration
Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

A720 Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

A730 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.

A740 Extended exenteration
Includes pelvic blood vessels or bony pelvis

A800 (Salpingo-) oophorectomy, NOS

Specimen sent to pathology from surgical events A250-A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

PROSTATE (C61.9)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item *Hematologic Transplant and Endocrine Procedures.*

Codes

A000 None; no surgery of primary site; autopsy ONLY

A180 Local tumor destruction or excision, NOS

A190 Transurethral resection (TURP), NOS, and no specimen sent to pathology or unknown if sent

Unknown whether a specimen was sent to pathology for surgical events coded A180 or A190 (principally for cases diagnosed prior to January 1, 2003).

A100 Local tumor destruction, NOS
- A140 Cryoprostatectomy
- A150 Laser ablation
- A160 Hyperthermia
- A170 Other method of local tumor destruction

No specimen sent to pathology from surgical events A100-A170.

A200 Local tumor excision, NOS
- A210 Transurethral resection (TURP), NOS, with specimen sent to pathology
- A220 TURP – cancer is incidental finding during surgery for benign disease
- A230 TURP – patient has suspected/known cancer
- Any combination of A200-A230 WITH
  - A240 Cryosurgery
  - A250 Laser
  - A260 Hyperthermia

A300 Subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact

A500 Radical prostatectomy, NOS; total prostatectomy, NOS
Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck.

A700 Prostatectomy WITH resection in continuity with other organs; pelvic exenteration
Surgeries coded A700 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.

A800 Prostatectomy, NOS

Specimen sent to pathology from surgical events 20-80.

A900 Surgery, NOS

A990 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 9975-9993)

Codes

A000 None; no surgery of primary site; autopsy ONLY

A120 Local tumor destruction, NOS

No specimen sent to pathology from surgical event A120.

A200 Local or partial excision of testicle

A300 Excision of testicle WITHOUT cord

A400 Excision of testicle WITH cord or cord not mentioned (radical orchiectomy)

A800 Orchiectomy, NOS (unspecified whether partial or total testicle removed)

Specimen sent to pathology from surgical events A200-A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

KIDNEY, RENAL PELVIS, AND URETER (C64.9 – C66.9)
Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
- A110 Photodynamic therapy (PDT)
- A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- A130 Cryosurgery
- A140 Laser
- A150 Thermal ablation

No specimen sent to pathology from surgical events A100-A150.

A200 Local tumor excision, NOS
- A260 Polypectomy
- A270 Excisional biopsy
- Any combination of A200, A260, A270 WITH
  - A210 Photodynamic therapy (PDT)
  - A220 Electrocautery
  - A230 Cryosurgery
  - A240 Laser ablation
  - A250 Laser excision

A300 Partial or subtotal nephrectomy (kidney or renal pelvis) or partial ureterectomy (ureter)

Procedures coded A300 include, but are not to limited to:
- Segmental resection
- Wedge resection

A400 Complete/total/simple nephrectomy – for kidney parenchyma
Nephroureterectomy
Includes bladder cuff for renal pelvis or ureter

A500 Radical nephrectomy

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

A700 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.

A800 Nephrectomy, NOS
Ureterectomy, NOS

Specimen sent to pathology from surgical events A200-A800.

A900 Surgery, NOS

A990 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 9975-9993)

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
- A110 Photodynamic therapy (PDT)
- A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- A130 Cryosurgery
- A140 Laser
- A150 Intravesical therapy
- A160 Bacillus Calmette-Guerin (BCG) or other immunotherapy

Also code the introduction of immunotherapy in the immunotherapy items. If immunotherapy is followed by surgery of the type coded A200-A800, code that surgery instead and code the immunotherapy only as immunotherapy.

No specimen sent to pathology from surgical events A100-A160.

A200 Local tumor excision, NOS
- A260 Polypectomy
- A270 Excisional biopsy

Combination of A200, A260, or A270 WITH
- A210 Photodynamic therapy (PDT)
- A220 Electrocautery
- A230 Cryosurgery
- A240 Laser ablation
- A250 Laser excision

A300 Partial cystectomy

A500 Simple/total/complete cystectomy

A600 Complete cystectomy with reconstruction
- A610 Radical cystectomy PLUS ileal conduit
- A620 Radical cystectomy PLUS continent reservoir or pouch, NOS
- A630 Radical cystectomy PLUS abdominal pouch (cutaneous)
- A640 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 A600-A640).

A700 Pelvic exenteration, NOS

A710 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 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 A600-A640).

A720 Posterior exenteration

For females, also includes removal of vagina, rectum and anus.
For males, also includes prostate, rectum and anus.

A730 Total exenteration

Includes all tissue and organs removed for an anterior and posterior exenteration.

A740 Extended exenteration

Includes pelvic blood vessels or bony pelvis.

A800 Cystectomy, NOS

Specimen sent to pathology from surgical events A20-A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

BRAIN AND OTHER PARTS OF CENTRAL NERVOUS SYSTEM (C70.0 – C72.9)
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, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

Do not code laminectomies for spinal cord primaries.

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Tumor destruction, NOS

No specimen sent to pathology from surgical event A100.

Do not record stereotactic radiosurgery (SRS), Gamma knife, Cyber knife, Linac radiosurgery as surgical tumor destruction. All of these modalities are recorded in the radiation treatment fields.

A200 Local excision of tumor, lesion or mass; excisional biopsy

A210 Subtotal resection of tumor, lesion or mass in brain

A220 Resection of tumor of spinal cord or nerve

A300 Radical, total, gross resection of tumor, lesion or mass in brain

A400 Partial resection of lobe of brain, when the surgery can not be coded as A200-A300

A550 Gross total resection of lobe of brain (lobectomy)

Codes A300 -A550 are not applicable for spinal cord or spinal nerve primary sites.

Specimen sent to pathology from surgical events A200 - A550.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

THYROID GLAND (C73.9) (01/01/2023)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

(Diagnosed 01/01/2023-12/31/2023)

Codes

A000 None; no surgery of primary site; autopsy ONLY

A130 Local tumor destruction, NOS

No specimen sent to pathology from surgical event A130.

A250 Removal of less than a lobe, NOS
- A260 Local surgical excision
- A270 Removal of a partial lobe ONLY

A200 Lobectomy and/or isthmectomy
- A210 Lobectomy ONLY
- A220 Isthmectomy ONLY
- A230 Lobectomy WITH isthmus

A300 Removal of a lobe and partial removal of the contralateral lobe

A400 Subtotal or near total thyroidectomy

A500 Total thyroidectomy

A800 Thyroidectomy, NOS

Specimen sent to pathology from surgical events A250-A800.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

Terminology (Robbins et al. 1991):
A radical neck dissection includes the removal of all ipsilateral cervical lymph node groups, i.e., lymph nodes from levels I through V (submental, submandibular, cranial jugular, medial jugular, caudal jugular, dorsal cervical nodes along the accessory nerve, and supraclavicular), and removal of the spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle.

In a modified radical neck dissection the same lymph nodes are removed as in a radical neck dissection; however, one or more non-lymphatic structures are preserved.

A selective neck dissection is neck dissection with preservation of one or more lymph nodes group routinely removed in radical neck dissection.

THYROID GLAND (C73.9) (01/01/2024)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

(Diagnoses 01/01/2024+)

Codes

B000 None; no surgery of primary site; autopsy ONLY

B130 Local tumor destruction, NOS
No specimen sent to pathology from surgical event B130

B200 Removal of less than a lobe, NOS
- B210 Local surgical excision
- B220 Removal of a partial lobe ONLY

B250 Lobectomy and/or isthmectomy
- B251 Lobectomy ONLY (right or left)
- B252 Isthmectomy ONLY
- B253 Lobectomy WITH isthmus

B300 Removal of a lobe and partial removal of the contralateral lobe

B400 Subtotal or near total thyroidectomy

B500 Total thyroidectomy

B800 Thyroidectomy, NOS
Specimen sent to pathology from surgical events B200-B800

B900 Surgery, NOS

B990 Unknown if surgery performed; death certificate ONLY

LYMPH NODES (C77.0 – C77.9)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

Codes
A000 None; no surgery of primary site; autopsy ONLY

A190 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded to A190 (principally for cases diagnosed prior to January 1, 2003).

A150 Local tumor destruction, NOS
No specimen sent to pathology from surgical event A150.

A250 Local tumor excision, NOS
Less than a full chain, includes an excisional biopsy of a single lymph node.

A300 Lymph node dissection, NOS
A310 One chain
A320 Two or more chains

A400 Lymph node dissection, NOS PLUS splenectomy
A410 One chain
A420 Two or more chains

A500 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)
A510 One chain
A520 Two or more chains

A600 Lymph node dissection, NOS and partial/total removal of adjacent organ(s) PLUS splenectomy
(Includes staging laparotomy for lymphoma.)
A610 One chain
A620 Two or more chains

Specimen sent to pathology from surgical events A250-A620.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

ALL OTHER SITES

C14.2-C14.8	**C31.0-C31.9**	**C51.0-C51.9**	**C68.0-C68.9**
C17.0-C17.9	**C33.9**	**C52.9**	**C69.0-C69.9**
C23.9	**C37.9**	**C57.0-C57.9**	**C74.0-C74.9**
C24.0-C24.9	**C38.0-C38.8**	**C58.9**	**C75.0-C75.9**
C26.0-C26.9	**C39.0-C39.9**	**C60.0-C60.9**	
C30.0-C30.1	**C48.0-C48.8**	**C63.0-C63.9**	

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

Codes

A000 None; no surgery of primary site; autopsy ONLY

A100 Local tumor destruction, NOS
- A110 Photodynamic therapy (PDT)
- A120 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- A130 Cryosurgery
- A140 Laser

No specimen sent to pathology from surgical events A100-A140.

A200 Local tumor excision, NOS
- A260 Polypectomy
- A270 Excisional biopsy
- Any combination of A200, A260, or A270 WITH
  - A210 Photodynamic therapy (PDT)
  - A220 Electrocautery
  - A230 Cryosurgery
  - A240 Laser ablation
  - A250 Laser excision

A300 Simple/partial surgical removal of primary site

A400 Total surgical removal of primary site; enucleation
- A410 Total enucleation (for eye surgery only)

A500 Surgery stated to be “debulking”

A600 Radical surgery
Partial or total removal of the primary site WITH resection in continuity (partial or total removal) with other organs.

Specimen sent to pathology from surgical events A200-A600.

A900 Surgery, NOS

A990 Unknown if surgery performed; death certificate ONLY

UNKNOWN AND ILL-DEFINED PRIMARY SITES (C76.0 – C76.8, C80.9)

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

Code

A980 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 or Surgical Procedure/Other Site at This Facility.

APPENDIX H: FIPS CODES FOR COUNTIES IN STATES ADJOINING INDIANA

State Name: Illinois

FIPS Code	County
001	Adams
003	Alexander
005	Bond
007	Boone
009	Brown
011	Bureau
013	Calhoun
015	Carroll
017	Cass
019	Champaign
021	Christian
023	Clark
025	Clay
027	Clinton
029	Coles
031	Cook
033	Crawford
035	Cumberland
037	DeKalb
039	De Witt
041	Douglas
043	DuPage
045	Edgar
047	Edwards
049	Effingham
051	Fayette
053	Ford
055	Franklin
057	Fulton
059	Gallatin
061	Greene
063	Grundy
065	Hamilton
067	Hancock
069	Hardin
071	Henderson
073	Henry
075	Iroquois
077	Jackson
079	Jasper
081	Jefferson
083	Jersey
085	Jo Daviess
087	Johnson
089	Kane
091	Kankakee
093	Kendall
095	Knox
097	Lake
099	La Salle
101	Lawrence
103	Lee
105	Livingston
107	Logan
109	McDonough
111	McHenry
113	McLean
115	Macon
117	Macoupin
119	Madison
121	Marion
123	Marshall
125	Mason
127	Massac
129	Menard
131	Mercer
133	Monroe
135	Montgomery
137	Morgan
139	Moultrie
141	Ogle
143	Peoria
145	Perry
147	Piatt
149	Pike
151	Pope
153	Pulaski
155	Putnam
157	Randolph
159	Richland
161	Rock Island
163	St. Clair
165	Saline
167	Sangamon
169	Schuyler
171	Scott
173	Shelby
175	Stark
177	Stephenson
179	Tazewell
181	Union
183	Vermilion
185	Wabash
187	Warren
189	Washington
191	Wayne
193	White
195	Whiteside
197	Will
199	Williamson
201	Winnebago
203	Woodford

State Name: Kentucky

FIPS Code	County	FIPS Code	County	FIPS Code	County
001	Adair	081	Grant	161	Mason
003	Allen	083	Graves	163	Meade
005	Anderson	085	Grayson	165	Menifee
007	Ballard	087	Green	167	Mercer
009	Barren	089	Greenup	169	Metcalfe
011	Bath	091	Hancock	171	Monroe
013	Bell	093	Hardin	173	Montgomery
015	Boone	095	Harlan	175	Morgan
017	Bourbon	097	Harrison	177	Muhlenberg
019	Boyd	099	Hart	179	Nelson
021	Boyle	101	Henderson	181	Nicholas
023	Bracken	103	Henry	183	Ohio
025	Breathitt	105	Hickman	185	Oldham
027	Breckinridge	107	Hopkins	187	Owen
029	Bullitt	109	Jackson	189	Owsley
031	Butler	111	Jefferson	191	Pendleton
033	Caldwell	113	Jessamine	193	Perry
035	Calloway	115	Johnson	195	Pike
037	Campbell	117	Kenton	197	Powell
039	Carlisle	119	Knott	199	Pulaski
041	Carroll	121	Knox	201	Robertson
043	Carter	123	Larue	203	Rockcastle
045	Casey	125	Laurel	205	Rowan
047	Christian	127	Lawrence	207	Russell
049	Clark	129	Lee	209	Scott
051	Clay	131	Leslie	211	Shelby
053	Clinton	133	Letcher	213	Simpson
055	Crittenden	135	Lewis	215	Spencer
057	Cumberland	137	Lincoln	217	Taylor
059	Daviess	139	Livingston	219	Todd
061	Edmonson	141	Logan	221	Trigg
063	Elliott	143	Lyon	223	Trimble
065	Estill	145	McCracken	225	Union
067	Fayette	147	McCreary	227	Warren
069	Fleming	149	McLean	229	Washington
071	Floyd	151	Madison	231	Wayne
073	Franklin	153	Magoffin	233	Webster
075	Fulton	155	Marion	235	Whitley
077	Gallatin	157	Marshall	237	Wolfe
079	Garrard	159	Martin	239	Woodford

State Name: Michigan

FIPS Code	County
001	Alcona
003	Alger
005	Allegan
007	Alpena
009	Antrim
011	Arenac
013	Baraga
015	Barry
017	Bay
019	Benzie
021	Berrien
023	Branch
025	Calhoun
027	Cass
029	Charlevoix
031	Cheboygan
033	Chippewa
035	Clare
037	Clinton
039	Crawford
041	Delta
043	Dickinson
045	Eaton
047	Emmet
049	Genesee
051	Gladwin
053	Gogebic
055	Grand Traverse
057	Gratiot
059	Hillsdale
061	Houghton
063	Huron
065	Ingham
067	Ionia
069	Iosco
071	Iron
073	Isabella
075	Jackson
077	Kalamazoo
079	Kalkaska
081	Kent
083	Keweenaw
085	Lake
087	Lapeer
089	Leelanau
091	Lenawee
093	Livingston
095	Luce
097	Mackinac
099	Macomb
101	Manistee
103	Marquette
105	Mason
107	Mecosta
109	Menominee
111	Midland
113	Missaukee
115	Monroe
117	Montcalm
119	Montmorency
121	Muskegon
123	Newaygo
125	Oakland
127	Oceana
129	Ogemaw
131	Ontonagon
133	Osceola
135	Oscoda
137	Otsego
139	Ottawa
141	Presque Isle
143	Roscommon
145	Saginaw
147	St. Clair
149	St. Joseph
151	Sanilac
153	Schoolcraft
155	Shiawassee
157	Tuscola
159	Van Buren
161	Washtenaw
163	Wayne
165	Wexford

State Name: Ohio

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

GLOSSARY OF REGISTRY TERMS

Terms in *italics* are defined within this glossary.

Abbreviations Meaning

adj.	adjective
e.g.	for example
i.e.	that is
n.	noun
pl.	plural
v.	verb

A

abstract. n. A summary, abridgement, or abbreviated record of pertinent information about a patient, the *cancer*, the *cancer-directed treatment*, and the outcome; the form or computer screen used to collect such information for each case. v: The act of collecting and recording cancer information from a health record.

accession. v. To enter a *case* into a *cancer registry* and assign it a number.

accession number. A unique 9-digit number assigned to the patient by the *registrar* indicating the year in which the patient was first seen for *cancer* at the reporting institution (first four digits) and the sequential order in which the patient was identified by the registry or *abstracted* into the database (last five digits). The number is used for all additional *primaries* the patient may develop, regardless of the year in which subsequent reportable *tumors* occur.

accession register. An annual, sequential listing of all reportable cases included in the *registry*. The accession register must include the *accession/sequence* number, patient name, *primary site*, and *date of initial diagnosis*. In a manual *registry*, it may be useful to include the *class of case* category. The accession register serves to identify, count, and evaluate the annual caseload.

acinus (pl. acini). A small saclike dilatation, particularly one found in various glands; synonymous with alveolus.

ACoS. American College of Surgeons.

ACS. American Cancer Society.

adenocarcinoma. A carcinoma derived from glandular tissue or in which the cells are arranged in the form of glands; a *malignant adenoma*.

adenocarcinoma in an adenomatous polyp. *Adenocarcinoma* in a glandular polyp of the colon.

adenoma. A *benign* epithelial *tumor* with a gland-like structure or in which the cells are clearly derived from glandular epithelium.

adjunct. An accessory or auxiliary agent or measure used in the *treatment* of disease or in other procedures.

adjuvant therapy. A treatment modality given in conjunction with another treatment modality, such as adjuvant *chemotherapy* given after *surgery* or *radiation* has destroyed the clinically detectable *cancer* cells, to prevent or delay *recurrence*.

adrenalectomy. *Excision* of adrenal glands.

adrenocorticotropic hormone (ACTH). A hormone that acts primarily on the adrenal cortex, stimulating its growth and its secretion of corticosteroids.

age specific rate. An incidence rate derived from analysis of data collected for a specific age group.

AJCC. American Joint Committee on Cancer.

allogenic cells. Cells belonging to or obtained from the same species but that are genetically different.

alphabetic. A term used to describe a data field that will accept letters only.

alphanumeric. A term used to describe a data field that will accept either letters or numbers but no special characters.

analytic case. A *cancer case* diagnosed and/or receiving all or part of the *first course* of treatment at the reporting facility. Analytic cases are eligible for inclusion in that registry's statistical reports of treatment efficacy and survival.

anaplasia. Reversion of cells to a more primitive or less differentiated form, a characteristic of *malignant tumors*; also called dedifferentiation.

anastomosis. A union or connection between two normally separate spaces or organs; typically used in describing a surgical connection between segments in the colon.

anatomic site. The place, position or location within the anatomy or structure of the organism.

ancillary drugs. Medications that enhance the effects of the *cancer-directed treatment* but do not directly affect the *cancer*. Ancillary drugs are not to be coded as cancer-directed treatment.

annual report. A publication produced on a yearly basis that describes the activities of an organization. For a *cancer* program, the report also includes statistics on the types of cancer diagnosed and treated at the facility.

autopsy. Postmortem *pathologic* examination of a body. Autopsy reports are used in *casefinding*.

B

basal cell. The predominant cell of the deepest layer of the epidermis.

basement membrane. A sheet of extracellular material interposed between cellular elements and underlying connective tissue. The sheet functions as a filtration barrier and a boundary that helps to generate and maintain tissue structure. In skin, it is the layer called basal lamina that marks the junction of the dermis and epidermis.

beam radiation. *Radiation* administered from an external source that may be either x-ray or cobalt.

behavior. Description of how a *tumor* acts in terms of whether it is *benign*, non*invasive*, *malignant*, or *metastatic*.

benign. Not *malignant*; not *recurrent*; favorable for recovery.

bilateral organs. Organs that occur as pairs, having a corresponding part on each side of the body.

biologic response modifier therapy. See *immunotherapy*.

biopsy. The removal of tissue for microscopic examination performed to establish a *diagnosis* and the characteristics of the *cancer*.

biostatistics. The application of statistics to the analysis of biological and medical data.

blastoma. A *neoplasm* composed of embryonic cells.

blood dyscrasia. A disease or *pathologic* condition of the blood.

bone marrow transplant. A type of treatment in which the patient's bone marrow is destroyed or reduced with high-dose *chemotherapy*, with or without total body irradiation, after which bone marrow is returned to the body to restore marrow and immune system function.

borderline neoplasm. A *tumor* with a *behavior* type that cannot be determined to be completely *benign*, yet which does not meet all criteria for *malignancy*.

Bowen disease. A squamous cell *carcinoma in situ* occurring usually on sun-exposed areas of skin, but sometimes found on mucous membranes; also called Bowen *precancerous* dermatosis and precancerous dermatitis.

brachytherapy. A type of *radiation therapy* where the radiation source is placed in direct contact with the *tumor*; for example, *cesium* capsules inserted into the uterus for treatment of endometrial *cancer*.

BRM. *Biological Response Modifier*; see *immunotherapy*.

C

CA. Cancer.

cancer. A cellular *tumor* exhibiting the characteristics of *anaplasia* and *invasion* and the potential for *metastasis*.

cancer-directed treatment (or therapy). *Treatment* that is *tumor* directed. Its purpose is to modify, control, remove, or destroy primary or *metastatic* cancer tissue; excludes treatment solely for the relief of symptoms.

cancer (or tumor) registrar. An individual employed by a hospital or other institution for the purpose of recording, *abstracting*, and coding *cancer cases*. A cancer registrar collects and stores information on cancer patients, conducts periodic follow-up on these patients, and prepares reports on the data collected.

cancer (or tumor) registry. A data system designed for the collection, management, and analysis of data on persons with the *diagnosis* of a *malignant* disease (cancer).

carcinoma. A *malignant tumor* of epithelial origin.

carcinomatosis. Invasion of many organs of the body at the same time by *metastases*.

case. An occurrence of a *primary site* of a reportable *cancer*. One patient with two primary cancers represents two cases. See Chapter 3 and Appendix B for the State Cancer Registry's *reportable list*.

casefinding. Systematic identification of all reportable *cancer cases* in a defined population, such as patients of a hospital or patients seen in a physician's office; also called case ascertainment.

Caucasian. Of or relating to the white race as defined by law.

cautery. The application of an agent which destroys tissue by burning or searing.

CDC. Centers for Disease Control and Prevention.

cesium. A metallic element used in isotopic form as a *radiation* source for *cancer-directed treatment*.

chemotherapy. *Treatment* by administration of a chemical or drug that inhibits the reproduction of *cancer* cells and that does not achieve its effect through change of the hormone balance.

class of case. A registry term describing whether a case is *analytic* or *nonanalytic* based on where the initial *diagnosis* and *treatment* of the patient occurs.

clinical case. A *cancer case* for which the *diagnosis* is not *microscopically confirmed*.

cluster. An aggregation of cases of a disease or other health-related condition which are closely grouped in time and place.

CoC. Commission on Cancer of the American College of Surgeons.

code. Alphabetic and/or numeric characters representing information in a data set or report.

colposcope. A speculum for examining the vagina and cervix.

comedocarcinoma. A type of ductal beast *carcinoma* whose central cells are degenerated and easily expressed from the cut surface of the *tumor*.

computerized axial tomography (CT or CAT). A *radiographic* method of examining the body by creating an image from cross-sectional computerized “slices” of tissue. The computer calculates the degree of multiple x-ray beams that are not absorbed by all the tissue in its path and creates a computer image showing the geography and characteristics of tissue structures within solid organs.

confidentiality. The concept of maintaining the privacy of personal information obtained in the process of work.

consultation. Advice and counsel given about a patient by a physician who provides no *treatment* to that patient.

contiguous. Adjacent, touching, in contact with.

contralateral. Situated on or pertaining to the opposite side.

core data set. See *required data set*.

cryosurgery. Destruction of tissue by selective application of extreme cold.

CTR. Certified Tumor Registrar.

-cyte, cyto-. Greek combining forms meaning pertaining to a cell.

cytology. The study of cells, their origin, structure, function, and *pathology*; the *microscopic* examination of cells obtained by aspirations, washings, scrapings, and *smears*.

D

DAM. *Data Acquisition Manual* (from the Commission on Cancer, ACoS), revised September 1994.

date of first recurrence. The point (month, day, and year) a *cancer* reappears after a disease-free interval.

date of initial diagnosis. The first time (month, day, year) that a recognized medical practitioner states that a patient has *cancer*, usually the date of first positive *tissue specimen*, although the first *diagnosis* can be *clinical* and may never be confirmed by *histology*.

date of last contact. The most recent point (month, day, and year) that a patient's vital status is known.

death rate. The number of deaths occurring over a given period of time divided by the number of persons at risk of dying during the same time period; also called *mortality rate*.

debulking. The surgical removal of as much *tumor* as possible, with or without total removal of the primary tumor, so that *adjuvant therapy* will be more effective; also called cytoreductive *surgery*.

definitive treatment. See *cancer-directed treatment*.

demography. The study of populations, especially with reference to size and density, fertility, mortality, growth, age distribution, migration, and vital statistics, and the interaction of all these with social and economic conditions.

derm-. Greek combining form meaning pertaining to skin.

diagnosis (pl. diagnoses). The identification of the presence, nature, and extent of a disease.

diagnostic (or disease) index. A listing of diagnoses for patients diagnosed or treated during a given time period. The listing is arranged in diagnostic groupings according to a specific coding system. The index is a source for *cancer casefinding*.

differentiation. The degree to which a *tumor* resembles the normal tissue from which it arose; also called *grade*. Differentiation reflects the aggressiveness of the tumor.

direct extension. A term used in *staging* to indicate *contiguous* growth of *tumor* from the *primary site* into an adjacent organ or surrounding tissue.

direct visualization. *Gross observation* of a *cancer* mass usually made at the time of *surgery* or *autopsy*.

disease free. Absence of any detectable *cancer* (including *recurrence* over a specified period of time).

dissection. The act of cutting apart or separating tissue.

disseminated. Scattered; distributed over a considerable area; in registry terms, describes a *tumor* that has spread throughout the body. Some tumors, such as *leukemias*, are disseminated at diagnosis. Others become disseminated as the result of *metastasis*.

distant. A term describing *stage of disease* for a *malignant neoplasm* that has spread to parts of the body remote from the primary tumor either by direct extension (beyond immediately adjacent organs or tissues) or by discontinuous *metastasis* (e.g., implantation or seeding) to distant organs, tissues, or via the lymphatic system to distant lymph nodes. Stage of disease for all *leukemias* and *multiple myelomas* is distant.

E

-ectomy. Suffix meaning *excision* or cutting out of an organ or part.

edit check. Computerized comparison of data fields for logic and accuracy.

en bloc resection. The removal of organs in one piece at one time.

endocrine surgery. Removal of an endocrine gland to stop growth of a *cancer* in another organ, when the hormonal product of the endocrine gland is implicated in the growth of the *tumor*; e.g., *orchiectomy* performed for cancer of the prostate.

endocrine therapy. See *hormone therapy*.

endoscopy. The visual inspection of any body cavity with an endoscope, an instrument for the examination of the interior of a hollow organ.

endothelium. The layer of epithelial cells that lines the cavities of the heart, blood and lymph vessels, serous cavities, and wall linings of hollow organs.

end results. The evaluation of *cancer treatment* through the analysis of patient *survival* after treatment.

EOD. *Extent of disease*.

excision. The act of removing, as of an organ or *tumor*, by cutting.

excisional biopsy. Surgical removal of an entire small *tumor*, for whatever purpose; a *biopsy,* performed to identify the cell type of the tumor, that removes the entire tumor.

exenteration. Surgical removal of the inner organs; the term is commonly used to indicate radical *excision* of the contents of a body cavity, as of the pelvis.

exfoliative cytology. *Microscopic* examination of cells shed from a body surface as a means of detecting *malignant* change.

extended data set. See *optional data set*.

extent of disease. Detailed description of how far the disease has spread from the *primary site* of a *cancer* at the time of *diagnosis*.

F

first course. The initial planned course of *treatment* or *therapy* for a specific *cancer*. Such treatment is typically initiated within four months following *diagnosis*, but may be initiated later than four months post-diagnosis (e.g., *consultation* irradiation given after completion of *chemotherapy*).

flag. In *registry* and computer terms, a data field that indicates a special status; for example, an incomplete *case* or a data field requiring an *override*.

flow cytometry. A special diagnostic technique used for DNA analysis of a *tumor*. The information, called DNA ploidy value, has prognostic clinical significance for some tumors.

focus (pl. foci). The chief center of a morbid process.

follow-up. Continued surveillance of a patient at specified intervals (usually twelve months) for the remainder of the patient's life following the initial *diagnosis* and *treatment* of a *cancer*. A documented contact with the patient, preferably through the attending physician, or through the spouse, a relative, or direct contact with the patient.

FORDS. *Facility Oncology Registry Data Standards* (from Vol. II, Standards of the Commission on Cancer, ACoS)

frozen section. A *pathologic* examination technique where part of a *biopsy* is quickly frozen, sliced thinly, and microscopically examined to determine the presence or absence of *cancer* cells. The technique is used for immediate *diagnosis* at the time of *surgery* so that, if indicated, more definitive surgical *treatment* can be completed at that time.

fulguration. Destruction of abnormal tissue by means of electric arc (indirect), or spark (direct), generated by high frequency current.

G

glioma. A *tumor*, usually associated with the brain, arising from the supporting structure of nervous tissue, including astrocytoma, oligodendroglioma, and ganglioglioma.

grade. The degree to which a *tumor* resembles the normal tissue from which it arose; also called *differentiation*. Grade reflects the aggressiveness of the tumor.

gross anatomy. That which deals with structures that can be distinguished with the unaided eye; also called *macroscopic* anatomy.

gross observation. *Macroscopic* examination; examination with the unaided eye; also called *direct visualization*.

H

hematology. The branch of medical science concerned with the study of the structure, functions, and disease of blood and blood-forming organs.

hematopoietic. Pertaining to the tissues that generate blood components, such as the bone marrow and stem cells.

hepatic. Pertaining to the liver.

hermaphrodite. An individual having the reproductive organs and many of the secondary sex characteristics of both sexes.

histology. The department of anatomy concerned with study of the minute structure, composition and function of the tissues; the microscopic structure of tissue.

history of cancer. The medical background for a patient who has been previously diagnosed with one or more *cancers*. The patient may or may not be *disease free*.

homolateral. *Ipsilateral*; same side.

hormone therapy. *Cancer-directed treatment* that interferes with the growth of *cancer* tissue by changing the hormonal balance of the patient. Hormone therapy may involve the use of hormones, antihormones, steroids, *endocrine surgery*, or endocrine *radiation therapy*.

hyperbaric. Characterized by greater than normal pressure or weight; for example, applied to oxygen under greater than normal atmospheric pressure.

hypophysectomy. Surgical removal of the hypophysis or pituitary gland.

I

ICD-9. *International Classification of Diseases*, Ninth Revision.

ICD-9-CM. *International Classification of diseases, Clinical Modification*, 9th Revision, 4th Edition. This edition has been adapted for use in the United States. All codes are compatible with *ICD-9*.

ICD-10-CM. *International Classification of diseases, Clinical Modification*, 10th Revision.

ICD-O. *International Classification of Diseases for Oncology*, 1976.

ICD-O-FT. *International Classification of Diseases for Oncology*, Field Trial Edition, March 1988.

ICD-O-2. *International Classification of Diseases for Oncology*, Second Edition, 1990.

ICD-O-3. *International Classification of Diseases for Oncology*, Third Edition, 2000.

immunotherapy. *Cancer-directed treatment* that boosts, directs, or restores the body's normal immune system and enhances the body's own ability to fight *cancer*. It is almost always used as an *adjunct* to *surgery*, *radiation*, and/or *chemotherapy*. Also called *biologic response modifier* therapy.

incidence rates. The number of new cases of a disease occurring in a period of time divided by the number of persons at risk of getting the disease during that time. The result is frequently multiplied by a base number such as 1,000 or 100,000.

incision. The act of cutting; a cut.

incisional biopsy. Surgical removal of a portion of a *tumor* performed to establish a *diagnosis* and the characteristics of the *cancer*.

induration. The quality of being hard; used to describe fibrous or connective tissue adjacent to the *tumor* and is to be interpreted as extension of the *malignant* growth.

inpatient. A hospital patient who is admitted for acute or critical care which is expected to require more than an overnight stay and whom the hospital classifies as an inpatient.

in situ. A term describing the *behavior* of a *neoplasm* which has all the characteristics of malignancy except invasion of neighboring tissues. It has not penetrated the *basement membrane*. A *diagnosis* of in situ behavior must be based on microscopic examination of tissue. Some synonyms are *intraductal, intraepithelial*, noninvasive, and noninfiltrating. Other terms meaning in situ are listed in Chapter 5 in the section for behavior.

interferon. Any of a family of agents with immuno-regulating effects and used to treat some types of *cancer*. Interferons are *biological response modifiers*.

intracystic. Within a cyst.

intraductal. Situated or occurring within the duct of a gland; *in situ*.

intraepithelial. Situated among the cells of the epithelium; *in situ.*

intrathecal injection. Injection of a substance into the cerebrospinal fluid surrounding the brain and spinal cord.

invasion. The infiltration and active destruction of tissue below the *basement membrane*, a characteristic of a *malignant* growth. (***invasive*** adj.)

ipsilateral. Situated on or pertaining to the same side; *homolateral*.

J

JCAHO. Joint Commission on Accreditation of Healthcare Organizations.

K

L

laser surgery. Destruction of *cancer* tissue with a laser beam, most commonly used for vaginal or oral *tumors*.

laterality. Relationship to one side of the body or the other (left, right, both). Laterality is determined when the *primary site* is a *paired site*.

left-justified. A term describing characters in a data field when they are entered in the first space(s) to the left. Unused spaces at the right are left blank unless instructions specify otherwise.

lentigo maligna. A non-invasive melanotic freckle.

lentigo maligna melanoma. An invasive melanotic lesion.

lesion. Any *pathological* or traumatic discontinuity of tissue.

leukemia. A progressive, *malignant* disease of the blood-forming organs.

lobular neoplasm. A *neoplasm* resembling small lobes.

localized. A term describing *stage of disease* for an *invasive malignant neoplasm* that is confined entirely to the *organ of origin*.

lymphadenopathy. Disease of the *lymph nodes*, but not necessarily indicating *tumor* involvement.

lymph node. One of the accumulations of the lymphatic tissue organized as definite lymphatic organs, varying from 1 to 25 millimeters in diameter and situated along the course of lymphatic vessels.

lymphoma. Any *neoplastic* disorder of the lymphoid tissue. The term is often used alone to denote *malignant* lymphoma.

M

macroscopic. Visible to the unaided eye or without a microscope.

macroscopic confirmation. The process of supporting a *diagnosis* with evidence visible to the unaided eye.

magnetic resonance imaging (MRI). A diagnostic technique that uses an external magnetic field to visualize internal structures of the body by making it possible to distinguish between hydrogen atoms in different environments.

malignant. The tendency of a disease to become progressively worse and to result in death; having the properties of *anaplasia*, *invasion*, and *metastasis*; said of *tumors*.

malignant melanoma. A *malignant neoplasm* of melanocytes, usually developing from a nevus and consisting of black masses of cells with a marked tendency to *metastasize*.

malignant tumor. An uncontrolled, *invasive* growth capable of metastasizing (spreading to a distant part of the body). The opposite of *benign tumor*.

master patient index. The complete, alphabetized listing of every patient that has been *accessioned* into the *registry* since its *reference date*.

medulloblastoma. A radiosensitive *tumor* of undifferentiated neuroepithelial cells arising in the cerebellum.

melanoma. A *tumor* made up of melanin-pigmented cells (melanocytes). When used alone, the term refers to *malignant melanoma*.

mesentery. A membranous fold attaching organs to the body wall, most commonly used in reference to the fold attaching the small intestine to the dorsal body wall.

mesocolon. The section of *peritoneum* by which the colon is attached to the posterior abdominal wall. It is divided into ascending, transverse, descending, and sigmoid portions, according to the specific section of colon to which it gives attachment.

metastasis (pl. metastases). The transfer or spread of disease from the original *site* to another site not directly connected to it; the formation of a new *foci* of the disease. (v. ***metastasize.*** to spread.)

metastatic. Pertaining to the transfer (spread) of disease; spread to organs other than those listed in the *regional* areas; spread to other areas of the body; or spread to *lymph nodes* other than *regional lymph nodes*.

micrometastasis. Secondary *tumors* that are not visible to the unaided eye.

microscopic confirmation. The microscopic examination of tissue or cells removed from the *site* of a suspected *cancer* for the purpose of verifying a malignancy.

morbidity rate. An expression of the number of disease occurrences in a defined population during a specified interval of time.

morphology. The science concerned with the forms and structure of organisms; the form and structure of a particular organism, organ, or part.

mortality rate. An expression of the frequency of death occurring in a defined population during a specified interval of time.

multiple myeloma. A primary *malignant neoplasm* of plasma cells usually arising in the bone marrow and associated with skeletal destruction resulting in *pathological* fractures and bone pain.

myelodysplastic syndrome. A unique preleukemic condition in which the bone marrow shows progressive deterioration in red blood cell production, platelet formation, and white blood cell maturation.

myeloma. A *tumor* composed of a type of cell normally found in bone marrow.

N

NAACCR. North American Association of Central Cancer Registries.

National Center for Health Statistics. The federal center for health statistics. It is one of the Centers for Disease Control and Prevention.

NCI. National Cancer Institute.

necropsy. The postmortem examination of a body; *autopsy*.

neoadjuvant therapy. *Chemotherapy* given prior to surgical *resection* or *radiation therapy* to reduce the bulk of a locally advanced primary *cancer*.

neoplasm. Any new and abnormal growth, such as a *tumor*. (***neoplastic*** adj.)

NIH. National Institutes of Health.

non-analytic case. A *cancer case* that was diagnosed and received complete *first course* of treatment elsewhere prior to admission to the reporting facility, prior to the *cancer registry's reference date*, or diagnosed at *autopsy*. Such cases are generally not included in statistical reports of treatment and *survival*, but may be included in administrative reports.

non cancer-directed treatment. *Treatment* which prolongs the patient's life, alleviates pain, makes the patient comfortable, or prepares the patient for *cancer-directed treatment*. The treatment is not meant to destroy or control the *tumor* or delay the spread of disease.

NOS. Not otherwise specified.

nuclear medicine. The use of radioactive materials (isotopes) in *diagnosis* and *treatment* of disease; includes the application or internal use of radium, radioactive iodine, radioactive phosphorus, and radioactive gold, for example.

numeric. A term used to describe a data field that accepts numbers only.

O

-oma. Suffix meaning *tumor* or *neoplasm*; swelling.

omentum. A fold of the *peritoneum* extending from the stomach to adjacent organs in the abdominal cavity.

oncology. The study of *tumors* and *cancers*.

oophorectomy. The removal of an ovary or ovaries.

optional data set. Additional data items that may be collected as an extension of a *required data set*. These additional data items are optional and are not required for certification purposes by the ACoS; also called extended data set.

orchiectomy. The removal of one or both testes.

organ of origin. *Primary site* of *cancer*.

-oscopy. Suffix meaning the act of examining or looking into an organ using an instrument called a scope.

osseous. Pertaining to bone.

-ostomy. Suffix meaning the surgical creation of an artificial opening into a hollow organ or a new opening between two such structures. The term “ostomy” is used alone when the opening is formed between two hollow organs or between one or more such organs and the abdominal wall for discharge of intestinal contents or of urine.

other cancer-directed treatment. Any *cancer-directed treatment* that is not appropriately assigned to the other specific treatment codes; includes any experimental or newly developed method of treatment differing greatly from accepted types of cancer therapy.

-otomy. Suffix meaning the operation of cutting, or *incision*.

outpatient. A hospital or clinic patient whose care and management is expected to require less than a one day stay and whom the hospital classifies as an “outpatient;” ambulatory (care) patient and short stay patient are terms for certain types of outpatients.

override. To indicate that an inconsistency (identified by *edit check*) between data elements has been reviewed and the information has been found to be correct.

P

paired site. *Bilateral organs;* two corresponding body parts on opposite sides of the midline.

palliative. An adjective used to describe medical care intended to relieve symptoms or make the patient more comfortable, but not cure. Some of the treatments termed palliative fall within the definition of *cancer-directed treatment*, but others are excluded because they treat the patient but not the *cancer*. If the distinction cannot be discerned in the medical record, a physician must interpret the purpose of the treatment.

papillary. Pertaining to or resembling a papilla or nipple.

Pap smear. A type of *cytology* examination used for the detection and *diagnosis* of *malignant* and premalignant conditions of the female genital tract; Papanicolaou *smear* or test.

parietal. Of or pertaining to the walls of a cavity.

parietal peritoneum. *Peritoneum* lining the abdominal and pelvic walls, including the undersurface of the diaphragm.

pathologic, pathological. Of or relating to *pathology*; relating to or caused by disease.

pathology. The branch of medicine concerned with the study of the nature of disease, its causes, processes, and development, as well as the structural and functional changes in tissues and organs of the body which cause or are caused by disease.

peritoneal. Pertaining to the serous membrane lining the abdominopelvic walls and enveloping the *viscera*.

peritoneal fluid. Fluid from the serous membrane lining the abdominopelvic walls and *viscera*.

peritoneum. The serous membrane lining the abdominopelvic walls and enveloping the *viscera*; see also *parietal peritoneum* and *visceral peritoneum*.

pleura (pl. pleurae). The serous membrane enveloping the lungs and lining the thoracic cavity, completely enclosing the *pleural cavity*.

pleural cavity. The potential space between the *parietal* and *visceral pleurae*.

pleural fluid. Fluid from the serous membrane enveloping the lungs and lining the thoracic cavity.

precancerous. Pertaining to a condition that tends to become *malignant*.

prednisone. An adrenocortical steroid which, when used as part of a chemotherapeutic regimen, is considered *hormone therapy* for certain types of *cancer*.

primary site. The organ or tissue where a *cancer* originates; where the cancer started in the body.

primary site code. A three digit code designated for the specific *anatomic site* of the primary *cancer*.

Q

R

radiation. Energy transmitted in the form of rays, waves, or particles; usually referring to electromagnetic radiation when used without a modifier.

radiation therapy (radiotherapy). The *treatment* of disease by roentgen rays or other radiant energy. Use of external beams or internal radioactive implants independently; or before, during, or after *surgery* to kill *tumor* cells. Examples include *beam*, seed, needle, and radioactive drugs.

radiology. The science of radiant energy (such as x-rays) and radioactive substances; the use of radiant energy in the *diagnosis* and *treatment* of disease.

rate (incidence rate). A measure of the frequency with which an event (e.g., death or disease) occurs in relation to a unit of population over a specified period of time.

rectosigmoid. The upper portion of the rectum and the lower portion of the sigmoid colon.

recurrence. The return of a *cancer* after a clinically disease free interval.

reference date. The starting date for a *cancer registry* after which all eligible *cases* must be entered into the registry. The date must be January 1 of a given year.

regional. A term describing *stage of disease* for a *malignant neoplasm* that 1) has extended beyond the limits of the *organ of origin* directly into surrounding organs or tissues, 2) involves regional *lymph nodes* by way of the lymphatic system, or 3) has both regional extension and involvement of regional lymph nodes, with no evidence of *distant* spread.

registrar. See *cancer registrar.*

registry. See *cancer registry.*

remission. Complete or partial disappearance of the signs and symptoms of disease; the period in which a disease is under control.

reportable list. A list developed by a *cancer registry* that identifies all diagnoses and types of *cases* that are to be included in the registry and those that are to be excluded. It must include malignancies with a *behavior* code (fifth digit) of 2 or higher.

required data set. Minimum required information established by a cancer registry to be collected for each cancer case; also called core data set.

resection. *Excision* of a portion or all of an organ or other structure.

retinoblastoma. A *malignant tumor* arising from retinal germ cells and appearing in one or both eyes, usually in children under 5 years of age; *glioma* of the retina.

rhabdomyosarcoma. A *malignant* soft-tissue *tumor* of muscle origin.

right-justified. *A term describing characters in a data field when they are entered in the last space(s) to the right. Unused spaces preceding the string of characters are left blank unless instructions specify otherwise.*

* *After September 10, 2024, the state cancer registry software is SEER Data Management System (SEER DMS).*

ROADS. *Registry Operations and Data Standards* (from Volume II, Standards of the Commission on Cancer, ACoS), revised January 1998.

S

salvage therapy. Treatment given after the failure of *first cours*e of therapy in order to prolong survival or to improve quality of life; a second attempt to cure the patient; see also *subsequent treatment*.

sarcoma. A *malignant tumor* of mesodermal origin. The mesoderm is the embryonic germ layer from which the supporting structures of the body (bone, muscle, connective tissue) are derived.

secondary site. The organ to which a *malignant neoplasm* has spread from a *primary site*; *metastatic site*.

SEER. Surveillance, Epidemiology, and End Results Program of the National Cancer Institute.

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

sequence number. A number assigned to a *case* in a *cancer registry* that indicates the chronological order of all independent, primary malignancies diagnosed during the life of the patient, whether the *tumors* exist at the same or at different times.

sex-specific rate. An incidence or death rate calculated using data for one sex only.

simultaneous. Existing or occurring at the same time. Separate *cancers* are simultaneous if diagnosed within two months of each other.

site. The place, position or location; for *cancer*, the *anatomic site* where the malignancy occurs. See also *primary site* and *secondary site*.

site specific. Pertaining to a particular primary *cancer*; e.g., surgery codes are individualized to particular cancer *sites* (breast, colon, lung, etc.).

smear. A specimen for *microscopic* study prepared by spreading the material across a glass slide.

squamous cell. A flat, scalelike epithelial cell.

stage, stage of disease. A broad category which groups cases with similar prognoses based on how far the disease has spread from the *site* of origin at the time of *diagnosis*; e.g., *in situ*, *localized*, *regional*, or *distant*; or stage 0, I, II, III, or IV.

stem cell transplant. A type of *bone marrow transplant* in which stem cells (the immature cells from which all blood cells develop) are obtained from the bloodstream and then used to restore the bone marrow.

stereotactic technique (s. radiosurgery or surgery). Any of the techniques which use a system of three-dimensional coordinates to precisely locate the *pathologic lesion* or *tumor* to be removed or treated. The lesion is localized using precise images, usually made by *computerized axial tomography* or *magnetic resonance imaging*. The operative approach or irradiation is then directed by an apparatus called an arc guidance system.

STORE. *Standards for Oncology Registry Entry* (from Vol. II, Standards of the Commission on Cancer, ACoS)

subsequent treatment. *Treatment* administered after failure of the *first course*, due either to progression of the disease or lack of response to the initial treatment.

surgery. In *cancer-directed treatment*, an operative procedure to remove cancer tissue, even if the cancer tissue is known to be not entirely removed.

survival. The length of time a patient lives after some defined starting point; in *cancer* data management, the length of time after *diagnosis* of cancer.

T

teratoma. A true *neoplasm* made up of a number of different types of tissue, none of which is native to the area in which it occurs; most often found in the ovary or testis.

text. A term used to describe a data field that will accept any letter, number, symbol, or space; the narrative, descriptive information recorded in an abstract to justify the codes selected for the data items or to maintain information that is not coded at all.

therapy. The *treatment* of disease.

tissue specimen. Organs or tissue surgically removed for *pathological* examination and *diagnosis*.

TNM Staging. A *cancer* staging scheme developed by the American Joint Committee on Cancer that classifies primary ***t****umor, regional lymph* ***n****odes*, and *distant* ***m****etastasis*.

topography. The name of an *anatomic site* or region.

transsexual. A person whose external anatomy has been changed to that of the opposite sex.

treatment. The management and care of a patient for the purpose of combating disease.

tumor. A swelling or mass; a new growth of tissue in which the multiplication of cells is uncontrolled and progressive; also called *neoplasm*. A tumor can be either *benign* or *malignant*.

tumor board (cancer conference). A meeting of medical professionals where the *diagnosis* and *treatment* of patients with *cancer* is discussed.

tumor marker. A substance in tissue or body fluids that can be measured quantitatively by biochemical or immunochemical means in order to detect a *cancer* and possibly the organ where it resides, to establish the extent of *tumor* burden before *treatment*, and to monitor the response to therapy.

tumor registrar. See *cancer registrar*.

tumor registry. See *cancer registry*.

U

V

validity. The degree to which a measurement actually measures or detects what it is supposed to measure; accuracy.

visceral peritoneum. The *peritoneum* reflected at various places over the *viscera*, forming a complete covering for the stomach, spleen, liver, ascending portion of the duodenum, jejunum, ileum, transverse colon, sigmoid flexure, upper end of rectum, uterus, and ovaries. It also partially covers the descending and transverse portions of the duodenum, the cecum, ascending and descending colon, the middle part of the rectum, the posterior wall of the bladder, and the upper portion of the vagina. The *peritoneum* serves to hold the *viscera* in position.

viscus (pl. viscera). Any large interior organ in any one of the three great cavities of the body, especially in the abdomen.

W

Wilms tumor. A rapidly developing *malignant* mixed *tumor* of the kidneys, made up of embryonal elements; also called nephroblastoma. It usually affects children before the fifth year, but may occur in the fetus and rarely in later life.

X

Y

Z